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Volume XXXI

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Number 3

# MEMPHIS MEDICAL MONTHLY

MARCH, 1911.

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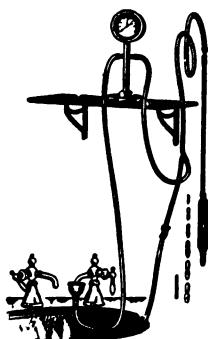
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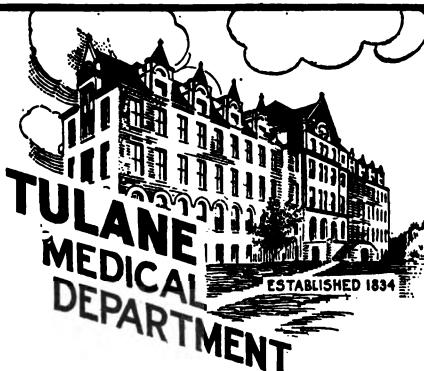
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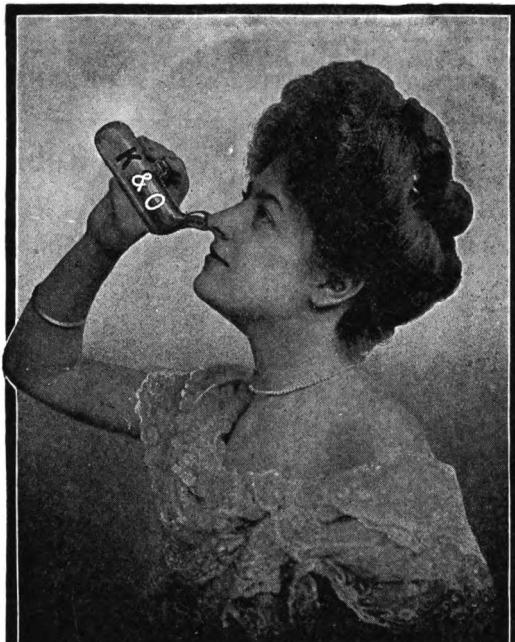
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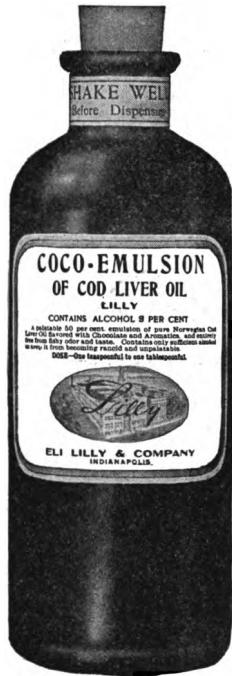
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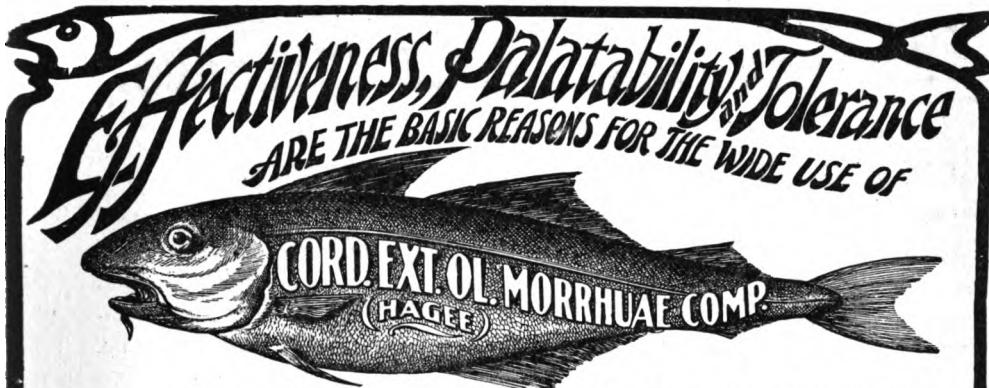
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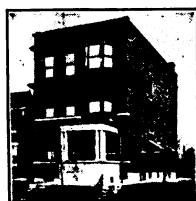
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# Memphis Medical Monthly

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MEMPHIS, TENNESSEE, MARCH, 1911.

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## ORIGINAL ARTICLES.

### DIAGNOSIS AND TREATMENT OF KIDNEY STONES.\*

W. S. ANDERSON, M.D.  
MEMPHIS.

The development of kidney stone surgery is interesting, and it is a remarkable fact that it was the year of 1880 before a stone was removed through the tissues of a fairly normal kidney. This operation was performed by Morris of England. From 1880 to 1898 other operators followed his teachings, and in 1898 he reported a series of 34 nephrolithotomies with the brilliant result of only one death. The operators of this period were considerably handicapped and their work was unsatisfactory, due to the uncertainty of the diagnosis.

During the last twelve years from 1898 to 1910 great strides have been made in the development of the surgery of the kidney, due to the use of the X-ray, the improved means of collecting the urine from the ureters separately, by segregators and urethral catheters, and various other improved aids in diagnosis.

The X-ray is by far the greatest aid in the diagnosis that we now possess. A few words in regard to the formation of kidney stone will not, I think, be amiss. Of all the probable factors, as gout, rheumatism, water, food and spinal injuries, the most important is infection.

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\*Read before the twenty-seventh annual meeting of the Tri-State Medical Association of Mississippi, Arkansas and Tennessee, at Memphis, November 15, 16 and 17, 1910.

I regard infection of a catarrhal type as the chief cause of stone formation, the germs as a rule being, as probably in gallstone of the typhoid and colon type. Statistics show that in about one-half of the cases there is only a single stone, but the number may be numerous. Likewise the size may vary considerably from that of a small grain to even two or three pounds. Single stones are usually oval or spherical, but are sometimes branched, assuming the shape of the pelvis and calices.

As a rule ureter stones are formed in the kidney. However, they may sometimes grow in the ureter and form long cucumber-like stones. There are several varieties of stones, produced by the numerous substances normally existing in the urine, the commoner forms being composed of phosphates, uric acid and urates, oxalates and calcium carbonate.

Stones frequently remain in the kidney for long periods of years, causing very little or no symptoms. They may also when small pass entirely through the urinary tract. Then, too, they may cause other symptoms, to which I will allude later.

In arriving at a diagnosis the careful history of the onset, duration and character of the attack is of great value.

Pain in varying degrees usually occurs in nearly all cases, but nephrolithiasis may occur without pain, as shown in Clark's report of 24 autopsies on calculus cases, 13 of these never having had any pain.

The size of the stone bears very little relation to the amount or character of pain. A small rough stone passing into and through the ureter may cause the most intense and agonizing pain on the one hand, while a large calculus in the pelvis of the kidney may give little or no pain.

Hematuria even in microscopical amounts occurring during or after an attack of renal colic is a point of considerable diagnostic value. The amount of blood in the urine may vary from a few corpuscles to large and even profuse quantities.

Rectal or vesical tenesmus is a frequent symptom caused by a stone in the ureter. Cystitis often accompanied by ureteritis and pyelitis from the presence of a stone will frequently give rise to frequent micturition.

The presence of renal sand, small calculi, small fragments of calculi and crystals, leucocytes and macroscopic pus are findings of considerable importance.

Cunningham reports a series of cases in which he found pus in 39 out of 48 cases.

Cystoscopy may throw considerable light on the case under diagnosis if the stone is in or near the ureteral orifice. A stone impacted in this orifice will be seen protruding or causing some prolapse, and a urethral bougie will show evidence of obstruction.

Examinations with ureteral catheters or Harris' segregator enables you to find from which side the pus and blood is coming and also to determine the functional capacity of the two kidneys.

Functional tests, as the indigo carmine and phloridzin, will sometimes be of benefit in doubtful cases.

The introduction of the X-ray as a means of diagnosis marks the most important advance made in kidney and ureteral stone surgery in modern times.

The technique of making these pictures has been so greatly improved during the past few years that no one these days should attempt to do an operation for the removal of kidney or ureteral stone without first having a skiagraph made.

The accuracy of the method depends largely upon the experience and skill of the operator making the examination and the interpretation of the plates.

The shadows made by the various calculi differ considerably, due to the difference in their density. Urate and uric acid stones show practically no shadow; fortunately they rarely occur.

The phosphatic stones stand next in point of density and the oxalates third. These two classes of calculi form the large majority of urinary concretions.

Along this line a word will not be amiss concerning the preliminary preparation of your patients for a Roentgen examination. A thorough emptying of the gastro-intestinal tract is very important. A brisk saline purge the night previous and a colonic flushing the morning of the examination. The patient should eat as little as possible for eighteen to twenty hours previous, in order to retard as much as possible the

peristaltic movement of the bowels, and to have the intestinal canal as empty as possible, so as to have very little to interfere with the details of the plate.

It is always advisable to have a picture taken of both kidneys and to also include the area of the uterus and bladder, for the clinical symptoms give us very little exact information in regard to the location of the stone.

The clinical picture of a renal calculi often resembles very closely that seen in other pelvic and abdominal troubles.

A careful study of the urine is of the greatest importance in cases of suspected stone.

Among some of the commoner conditions liable to be mistaken for stones are the following:

(1) Tumors and tuberculosis of the kidney, ureter and bladder. Finding of the tubercle bacilli in the tubercular cases or fragments of the tumor will give very positive evidence. In searching for the tubercle bacilli large quantities of the urine should be very carefully centrifuged and stained in order not to be confused with other findings, as the smegma bacilli.

(2) Acute or chronic appendicitis. Reliance must be placed upon the skiagraph in many of these cases in making the differential diagnosis.

(3) Movable or floating kidney with kinking of the ureter. Changing the posture of the patient, allowing the kidney to slip back in place and relieving the kink in the ureter will frequently alleviate these symptoms.

(4) Pain on the right side caused by biliary and pancreatic calculi and intestinal obstruction may be confusing. A careful history, study of the feces, and a skiagraphy will usually enable us to make a diagnosis. Gall stones, I will say, seldom cast a shadow with the X-rays.

(5) A psoas or perinephritic abscess. When a positive diagnosis of the presence of a stone, together with its size and location, has been made, I am in favor of surgical intervention, except where there is a strong contraindication, or when the stone is so small that it will in all probability be passed. Medical treatment is of very little benefit. There are some conditions, as calculous anuria, infection, etc., where there is no question about the propriety of surgical treatment.

One very strong argument in favor of the surgical removal of kidney stones where there are no urgent symptoms, is the prevention of such urgent symptoms by removing the stone which if left may in time cause them. It is well to know that in almost all cases, the kidney in which the stone is located continually suffers more or less from its presence; chronic changes are taking place with much impairment of the secreting value, even often leading to total destruction of the kidney tissue.

Where the skiagraph shows only a single stone and there are no clinical findings that point toward any material destruction of kidney tissue one may proceed at once with the operation without any further investigation, but if it shows a large single stone or several stones and the clinical symptoms point toward much destruction of kidney tissue, with pus and blood in the urine, an exhaustive study should be made of the case to ascertain the presence or absence of the other kidney and its functioning qualities, for one must be prepared for a nephrectomy, if necessary. This can be accomplished by collecting the urines separately by segregators or ureteral catheters.

I do not regard ureteral catheterization as entirely harmless, for there is a certain amount of danger of infecting the sound ureter.

If positive information can be obtained by catheterizing the diseased ureter alone, then the healthy one should not be catheterized. Unless this is possible then catheterize both.

The knowledge of the presence of both kidneys can be frequently obtained by observing with the cystoscope the presence of the two ureteral openings. In operating on cases of kidney stone the fact should always be kept in mind that about 20 per cent of these cases have stones in both kidneys.

The removal of a small single stone from the pelvis of the kidney not contaminated by infection or suppuration is not a severe operation. Pyelotomy or removal of the stone through the pelvis of the kidney is now the operation of choice.

Formerly it was thought that there was much more danger of urinary fistula in this operation than in cutting through the kidney substance, but the work of recent operations disproves

this. The advantages of such an operation are that it is much safer and far less bloody.

But if we have to deal with a large or branched stone, multiple stones or with a case where there is positive evidence of infection, then I prefer to do a nephrolithotomy, cutting directly through the convex border of the kidney substance down toward the pelvis.

In the placing of the patient on the operating table operators vary. Some prefer to place the patient on the stomach and to use the special elevator on the table, raising the patient, thus increasing the space between the last rib and the crest of the ilium. Others operate on the side, placing a pad under the flank, thus elevating the side. Most of my work has been done in the former position.

I employ the oblique kidney cut, beginning at a point just below the last rib, where it is crossed by the erector spinae, and continuing downward to within a finger's breadth of the crest of the ilium.

The length of the incision should be such as to give you free working room. This incision cuts through skin, superficial fascia, latissimus dorsi muscle, lumbar fascia and external oblique, and occasionally the internal oblique and transversalis muscles.

Expose the fatty capsule and carefully separate it from the kidney, lifting the kidney well up into the wound. If the stone is in the pelvis, expose well its posterior surface, where it is free from vessels, unless probably there may be some abnormal vessel. Make your incision directly into the pelvis, remove the stone and close the incision in the pelvis with a row of fine sutures. Replace the kidney and put a ciaqrette drain to its pelvis.

Close the external wound, suturing the deep muscles with catgut and the skin with catgut or silkwormgut. Remove the drain in four or five days. The skin sutures can be removed in seven or eight days and your patient can usually leave the hospital at the end of two weeks. If your case is one of nephrolithotomy, I prefer to have an assistant grasp the renal vessels to the use of clamps. After you cut through the kidney substance while your assistant makes pressure on the vessels, remove the stone or stones with care, trying to

avoid breaking them or leaving any particles of the stone. If there is no evidence of pus the kidney substance can be carefully sutured with catgut or packed. There is a certain amount of risk of a small fistula remaining from the needle wounds in the kidney substance, so I prefer to pack the wound in the kidneys with gauze, as I do in pus cases.

Packing well usually controls the bleeding. The packing will drain the kidney well and it should be allowed to remain until it loosens and then it can gradually be removed, and thus you avoid danger of secondary hemorrhage.

Many operations are now practiced for the removal of stones in the ureter, each depending on the location of the stone. I will not discuss them in this paper.

My last case required sixteen days before it could all be removed. This was a case of four large stones in the kidney tissue, and a great deal of pus in the urine. If the kidney is found much diseased it is best to remove it at the time of the first operation rather than to attempt it later, for this usually is a difficult as well as a dangerous operation on account of the many adhesions.

In conclusion, I think that we can today regard the diagnosis and treatment of kidney stones as one of the great triumphs of modern surgery from the two standpoints of saving life and relieving untold suffering.

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#### Dangers of Antimeningococcic Serum.

Netter, Courtois-Suffit and Dubosc (Rev. intrn. de med. et de chir., January 25th, 1910) caution practitioners against the dangers of too large or too prolonged injections of serum. In one case, apparently hypersensitive to the action of the treatment, symptoms of meningitis returned after a brief period of amelioration, and were found later to depend upon an attack of urticaria, which readily yielded to the administration of calcium chloride. When, however, injections of serum have been repeated for the purpose of treating this apparently fresh attack, really due to the serum itself, disastrous consequences, and even loss of life, have been the result. In all cases a careful investigation of the cerebrospinal fluid and the recognized presence of polynuclear and meningococcic cells must be made out before resorting to further injections of serum.—British Medical Journal.

**AIDS IN THE DIAGNOSIS OF NERVOUS DISEASES,  
WITH SPECIAL REFERENCE TO THE REFLEXES.\***

WILLIAM G. SOMERVILLE, M.D.

MEMPHIS.

There is perhaps no patient who requires such a careful and systematic examination as the one who consults the neurologist. It is the object in this paper to emphasize a few striking and important symptoms which when found in a general examination would suggest the existence of some nervous disease, and aid materially in arriving at a diagnosis, or at least lead up to a more thorough examination of the nervous system. In order to understand the symptoms more intelligently it is necessary to review a few important points of the physiology and anatomy of the nervous system.

The nervous system is composed of nerve cells with prolongations. This forms what is called a neuron and is made up of a cell body with its nucleus a long prolongation—the axon, which serves to carry impulses away from the cell body, and the short processes, dendrons, which carry impulses to the cell body. Each neuron is anatomically and physiologically an independent entity. The motor system has two sets of neurons, the upper and the lower neuron. The upper neurons begin in the cells of the motor area of the cerebral cortex (anterior central convolution); their axons pass downward through the internal capsule, decussating in greater part in the medulla, and, forming in the cord the pyramidal tracts, finally terminate at the cells of the anterior horn of the cord in their course down. The lower neurons begin in the cells of the anterior horn of the cord and, leaving the cord, form the anterior roots, their axons terminating in the muscles. The impulses of the motor neurons are descending or efferent. The arrangement of the sensory neurons is more complicated, and the impulses which they receive are ascending or efferent. They begin in the tissues of the body, enter the spinal cord by the posterior roots which they form, and conduct sensations of touch, pain,

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temperature, and also deep sensations (i. e., joint, muscle, tendon and bone sensations, including sense of position and pressure). They form the various ascending columns of the cord, namely:

- (1) The posterior columns, columns of Goll and Burdach.
- (2) The lateral columns, including the dorsal cerebellar tract (Fleschsig's), and the ventral cerebellar tract (Gower's).
- (3) A part of anterior ascending column.

The sensations of pain and temperature are conducted by the lateral columns and are crossed.

Sensations of touch are conducted by the posterior and anterior ascending columns jointly, and if either one or the other is divided there is no loss of sense of touch; they are partly crossed and partly direct.

The muscle sense is conducted by all the ascending tracts. A lesion may occur in the upper or lower motor neuron, and the symptoms found enable us to readily determine whether it is the upper or lower.

The upper motor neurons not only conduct impulses of voluntary motion, but also exert an inhibitory action or power of restraint upon the lower. The cells of the anterior horns of the cord, which are the starting points of the lower neuron, have a tropic influence over the muscles. Consequently in upper motor neuron lesions we have loss of voluntary control over the muscles and loss of inhibitory action; and the patient is unable voluntarily to move the muscles involved; and on account of restraint or loss of inhibition, we have later more or less rigidity of the muscles, increase of the tendon reflexes, and Babinski's phenomenon, which will be described later, and when present always means that there is a lesion of the pyramidal tracts.

But as neither the cells of the anterior horns nor their prolongations, the anterior roots and peripheral nerves, are involved, we have no tropic disturbances, that is to say, the muscles do not atrophy except slightly from disuse and they react normally to electricity.

In lesions of the lower motor neuron, whether occurring in the cells of the anterior horns, in the anterior spinal roots or in the peripheral nerves, we find flaccidity and marked atrophy

of the muscles, changes in electrical reactions and loss of reflexes, in addition to paralysis.

It is important to know why in lower motor neuron lesions we have a loss or diminution of the tendon reflexes, and in upper motor neuron lesions we have usually an increase of these reflexes.

The knee jerk or patella reflex is a good example of the deep reflexes, and is caused by a tap over the tendon of the quadriceps extensor. This acting as a stimulus sets up an impulse which travels upward along the sensory nerves, enters the posterior horns of the cord through the posterior roots (2-4 lumbar), is conducted thence to motor cells of the anterior horns, and there produces a descending impulse, which is transmitted along the motor nerve fibers to the quadriceps muscle, causes a contraction of this muscle and a consequent extension of the leg, or knee jerk.

Any lesion along this path will interrupt the impulse and cause a loss of this reflex. Thus in lesions of the peripheral nerves, as peripheral neuritis, or in lesions of the posterior roots, as tabes dorsalis, or in the lesions of the anterior horns, as anterior poliomyelitis, we have loss or diminution of the deep reflexes corresponding to the locality involved.

Besides the deep or tendon reflexes we have the superficial or skin reflexes, which are generally considered cerebral reflexes. The most important of these are the abdominal and plantar.

If we stroke or scratch with the point of a pencil the skin of the abdomen, right or left, upper or lower, we produce a reflex contraction of the corresponding muscles. This reflex can usually be elicited, especially in youthful individuals, but may be absent in those with very fat abdomens, or with very lax abdomens, as in those who have had frequent parturitions. Its absence except in cases just mentioned, may indicate a lesion in the upper motor neuron, occurring in disseminated sclerosis and in apoplexies.

Of far greater significance is the plantar reflex, which is obtained by scratching or stroking the sole of the foot from below upwards, that is, towards the toes. The great toe is the only one necessary to watch, and normally we get a flexion of this toe. Whenever there is a lesion of the motor tract, wheth-

er cortical, capsular or spinal, e. g., apoplexies or disseminated sclerosis, we get a rather slow extension of the great toe, i. e., a dorsal flexion takes place. This is called Babinski's phenomenon, plantar extensor response, or dorsal flexion of the great toe. It is, perhaps, the most important of all reflexes. Babinski's phenomenon when obtained always signifies that our patient has an organic and not a functional disease; and further that the lesion involves the pyramidal tract. It is a very common and often an early symptom of disseminated sclerosis, which disease is so frequently diagnosed as functional. Therefore it is very important to remember that when Babinski's phenomenon is found in a case supposed to be functional, one may be almost absolutely sure that he has one of disseminated sclerosis. It may be absent one day and present the next, consequently one should not be content with one or two trials to obtain it. The patient had best be placed in the recumbent position. Then one grasps the ankle, slightly flexes the knee and allows the limb to fall outward. This brings the plantar surface into good view. Now, with the point of a pencil, head of a pin or one's finger nail scratch or stroke gently the inside of plantar surface from below upward. If no response is obtained do the same over the outer side of plantar surface. If still not successful stroke from above downwards, and one can use more force, if gentle stroking does not suffice.

It is very important that the feet be warm in making the test, for it is often absent in pyramidal lesions when the feet are cold. An absence of both flexor and extensor response is rather significant of functional disorder.

There are four tendon reflexes which should always be tested, viz., wrist, elbow, knee and ankle, comparing right with left. A moderate increase in any one or all of these reflexes does not indicate organic disease, provided the two sides are equal, but an inequality does. An absence of one or both knee jerks indicates organic disease and means the reflex arc is broken. But before we should say it is absent, we must test it very carefully and thoroughly. It is better obtained if we have the patient turn the eyes upward, or have him hook the fingers of one hand in the other and at the moment we strike with the percussion hammer, have him pull one against the other.

One may fail to obtain any of the other reflexes in healthy individuals.

Sometimes without a very thorough examination it is difficult to differentiate tabes dorsalis and peripheral neuritis. Especially is this the case when we have the form of neuritis in which the sensory fibers are chiefly involved. Here we get very good power, but sensory disturbance and marked inco-ordination, just as we find in tabes, in which there is no motor paresis, unless complicated or in the last stages.

There is one little point which makes it easy to differentiate. Peripheral neuritis is an inflammatory condition and if one presses over the nerve trunks, e. g., in popliteal space, or pinch the tendon achilles or grasp the calf muscles very firmly, the patient will complain considerably of the pain, as the sensation for pain and deep pressure is plus. In tabes the sensation to deep pressure is diminished very markedly.

If one sees a patient in whom one or both pupils fail to react to light, but react by accommodation, the Argyll-Robertson pupil, it is almost a certainty that the patient has tabes dorsalis, dementia jaralytica or cerebro-spinal lues. Cases have been recorded where this symptom alone existed for years before the onset of other symptoms.

There is a syndrome of symptoms very characteristic of syringomyelia.

A patient complains that he cannot distinguish the difference when he places his hands in hot water and cold water. If we take two test tubes, one containing hot and one cold water, and apply sometimes one, sometimes the other, going over the hands, arms and upper part of the body, we find our patient cannot distinguish one temperature from the other. Pain is also lost or diminished—the prick of a pin is interpreted as a touch. But if we test his sensation of touch with a bit of cotton over this same region, we discover that it is intact. We notice also decided atrophy of the muscles about the shoulders and arms. With the symptoms, loss of temperature and pain sense with retention of sense of touch, and more or less muscular atrophy, occurring in the upper extremities usually, or in the lower, or both, we are justified in making a diagnosis of syringomyelia. We might, however, find this train of symptoms following an injury to the back, and

causing a hemorrhage into the central canal; but, in this case, the symptoms develop suddenly, while the gross lesion is the same in the two diseases.

There is a disease, the pseudo-hypertrophic form of the myopathies, which presents some characteristic symptoms making a diagnosis easy. It occurs in families usually beginning between the ages of 4 to 10. The early symptoms may be that the child is clumsy and gets frequent falls; but when fully developed the symptoms are very striking. Our little patient walks with a waddling gait, feet spread apart, body thrown back, and arms slightly flexed and adducted. If he is laid on his back and asked to get up, he first rolls over on abdomen, laboriously gets in the hand and foot position and then climbs up his legs and thighs by means of his hands to the erect position. The legs are well developed, due to a pseudo-hypertrophy, but there is in reality loss of power. There is usually present a true atrophy of certain muscles of upper arms and thighs.

The diagnosis of paralysis agitans, or Parkinson's disease, can frequently be made from the patient's gait and expression. He walks stiffly, with bowed head and body, and does not swing the arms, which are held rigidly. His steps are short and quick and when once started he has difficulty in stopping himself. In talking his face is expressionless and mask-like—the so-called Parkinson mask. In quite a number of cases we find no tremor, which when present is more noticeable when patient is at rest. The rigidity of the muscles is usually present and more frequently so than the tremor. When a patient complains of periodical headaches usually accompanied by vertigo and vomiting, we must suspect the possibility of brain tumor, and if we examine the eye grounds and find optic neuritis or choked disk of one or both eyes, we can with certainty diagnose brain tumor.

**ANEURYSMS OF THE ABDOMINAL AORTA.\***

W. T. PRIDE, M.D.

MEMPHIS.

An aneurysm may be defined as a blood tumor in direct communication with the cavity of the heart, the surface of a valve or the lumen of an artery. The frequency with which this occurs is probably more alarming than the general practitioner may grant; but its importance, at any rate, should urge us to a closer study and more careful examinations.

My subject today confines me to only a small part of this great field, but because of its importance and the frequency with which it is overlooked, I selected it.

Aneurysms of the abdominal aorta are in proportion to the thoracic, as one to ten or twenty, depending upon the particular locality and the habits of the people. Males are affected oftener than females, probably one to fifteen. The majority are in persons under 40 years of age and more common between 30 and 40. More common in soldiers, probably due, for the most part, to the frequent syphilitic infection. Common in the laboring classes, due to exposure, heavy work and a generally neglected life.

The location of the aneurysm is usually about the celiac axis; this we would expect from its position in regard to the diaphragm and internal organs giving pressure, and also to the change of the blood current at this point. Rarely one is found at the orifices of the superior mesenteric and renal arteries.

The form usually encountered in the abdomen is the sacular. This very often ruptures into the surrounding tissues, causing the diffuse form, this being the cause of some of the largest blood tumors of the abdomen. The sac usually arises from the posterior wall of the vessel, causing a most serious complication, erosion of the vertebrae, this, however, not being nearly so frequent as in the thoracic.

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The symptoms determine the diagnosis, hence if the physician has the symptoms at his finger's end (this may be taken literally also) any mistake or doubt will vanish. There are two or more reasons why we do not diagnose these cases—first, and most important, we do not take the trouble to examine our patient, but give something for the pain complained of; this may be a pain simulating cholangitis or cholelithiasis (the so-called gallstone colic), nephrolithiasis (kidney colic), gastric or duodenal ulcer, appendicitis, pancreatitis and intestinal complications of all kinds; secondly, our mistakes may be due to faulty methods of examination, and, thirdly, unfamiliarity with the condition.

To correct these, have the patient's body exposed at the point for examination and systematically inspect, palpate, auscultate and percuss. On inspection, we usually find the patient well preserved with probably nothing to guide us but a pulsation about the epigastrium, and even this is not always marked, and when present may be misleading, for in thin subjects, especially women who have borne children, some diastasis of the recti being present, the normal aorta can be seen to pulsate. This being true, lay your hand upon this point and you will find it expansive in character. (This is the keynote to the diagnosis.) Synchronous with the heart beat and transmitting a marked vibratory thrill, usually systolic in character, rarely double and transmitted along the vessels. The thrill in this form is always very marked.

Over the normal aorta, a throbbing, not expansile, diffuse in character, without localization or that punctate heaving quality as the aneurysms. Abscesses, when situated over a vessel, may be confusing, but they never have the expansile pulsation or the true auscultatory phenomena.

To confirm our findings we practice auscultation and find a very distinct systolic murmur or bruit with intensification of the heart sounds. The diastolic accentuation, when present, is a most valuable diagnostic sign. A bruit is heard in malignant vascular tumors, but is not heard along the vessels. Percussion may elicit a distinct tumor, but is of much less value than in the thorax.

Within the past few years the X-ray and fluoroscope have come to our aid in diagnosing this condition and no case, however certain we are, should fail to be shown in this manner.

There are a few symptoms common and peculiar to abdominal aneurysm, especially as regards pain and pressure. Pain is usually a more dominant feature than in the thoracic, according to the position of the sac and direction of the growth, will the symptoms assert themselves. Pressure upon the gall ducts gives symptoms of cholangitis or choledocholithiasis. Pressure upon the kidney nephritic colic, upon ureter hydronephrosis. Because of its relation to the stomach, nausea and vomiting may be present. Pressure upon the esophagus gives dysphagia, or upon the duodenum great dilatation of the stomach. Pressure upon the returning vessels of the lower extremities gives marked edema. When the situation is high up, pressure may cause cardiac embarrassment, giving symptoms of indigestion and rarely anginoid pains. The pain may be referred to the sternum, down to the hips, sacroiliac region or legs. This pain may be dull and gnawing in character or come on in crisis of intense agony. Rarely hematemesis is present from embolism of the gastric arteries or pressure upon the vasa brevia.

Termination.—Rupture is the most frequent mode of ending, and this may occur into the retroperitoneal tissues, peritoneal cavity, pleural cavity, mediastinum, pericardium, stomach, duodenum, colon, gall bladder, inferior vena cava or even the spinal canal. The rupture into the retroperitoneal tissues, which is the more common, may cause remarkable symptoms, the most common probably being that of an acute abdomen simulating appendicitis, abscess or any acute condition. On the other hand, there are many spontaneous cures, as proven by autopsy from other causes. Many apparently recover under judicious treatment, both medical and surgical.

The form of aneurysm has a great deal to do with the prognosis in any case. The saccular and dissecting probably being the more favorable. The average duration is about two years. The treatment consists of the prophylactic and curative. By prophylactic I mean the thorough treatment of all cases of syphilis and caution to all subjects of cardiovascular disorders. The curative treatment is very discouraging in many cases, but this is no plea for inaction. In every case there are certain indications to be met, viz.: (1) Relieve the aortitis; (2) diminish the force of the blood current; (3) ob-

tain a clot within the sac by fibrin formation. To this end we prescribe rest, and by this means absolute rest in bed. This must be kept up for months. Tufnell began this treatment about thirty-five years ago, together with a low diet and the administration of certain drugs as the symptoms demanded. The diet used by Tufnell consists of ten ounces of solids and eight ounces of fluid in the twenty-four hours. This diet, with some variation, together with potassium iodide, is probably the most efficient medicinal treatment of today.

Compression has been used successfully, but is always attended with great danger, many cases of peritonitis and intestinal gangrene having occurred. Dr. Keen devised an instrument for temporary compression after abdominal section, it being applied directly to the vessel.

Matas has operated with success in some cases by abdominal section and attaching the sac to the abdominal wall by adhesions, later introducing a wire and passing an electric current through it. Many are wired and MacEwen's needling operation performed.

The medical treatment has probably been the most successful and is attended with much less danger.

In conclusion, I will say that every pain within the abdomen may be caused by an aneurysm—every symptom, which is an expression of an abnormal abdomen, may have for its origin an aneurysm. Many cases of so-called heart failure are no doubt ruptured aneurysms—undiscovered during life by the physician. Therefore it behooves us to make more thorough examinations and study each and every case.

312 Memphis Trust Building.

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### **Bearded Woman.**

The bearded woman is not a fiction. A bearded woman was taken by the Russians at the battle of Poltawa and presented to the Czar. Her beard measured over a yard. The great Margaret, Governess of the Netherlands, had a very long, stiff beard. Mlle. Boes de Chene, born at Geneva in 1834, was exhibited in London in 1853, in her eighteenth year. She had a profuse head of hair, a large moustache and a strong, black beard. There are other instances of bearded women about the authenticity of which there is no room for doubt.—Ex.

Vol. 31—10

**BENIGN TUMORS OF THE UTERUS.\***

E. M. HOLDER, M.D.  
MEMPHIS.

It has long been a tradition in gynecology that fibroids of the uterus are benign tumors, which interfere only rarely with either the health or the life of the patient. A few enlightened and experienced surgeons have persistently endeavored for a quarter of a century to refute this fallacy, and this school of thinkers is today being recruited from all sides. The subject is being discussed in a mature way by the leaders of the profession at all the great medical centers of the world. The trend of this discussion may be summed up appropriately in the whole range of surgery more ironical than a woman spending twenty or even thirty years of her life as a chronic invalid on account of a uterine fibroid, in the expectation that at the menopause she will be restored to health and begin a new life, and then to realize that far from this dream being fulfilled the fibroid becomes necrotic, malignant or septic and places her life in the greatest peril, and that she may then die in spite of surgical interference.

It is already a surgical maxim that an ovarian tumor should always, whenever discovered, be removed, and it is to be hoped that this decade will bring uterine fibroids into this same class. Until recently the maxim in benign tumors of the uterus has been constant observation of the patient and her tumor and interfere surgically only when plain indications are present.

The tendency at this writing to underrate the dangers of fibromyomata when left alone, is giving way to a more enlightened understanding of the matter. In justification of this view, I quote from Dr. Scharlieb: "Several of my patients have had sarcomatous infiltration of a fibromyoma. Several such tumors have sloughed, many have been complicated by pyosalpinx, hydrosalpinx and other diseases of the adnexa. Indeed, I have learned to look on the supposed innocent fibroids as a fiend ready to play any nasty trick."

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\*Read before the twenty-seventh annual meeting of the Tri-State Medical Association of Mississippi, Arkansas and Tennessee, at Memphis, November 15, 16 and 17, 1910.

Noble, in a paper on "The Complications and Degenerations of Fibroid Tumors of the Uterus," compares the statistics of operative with expectant treatment. He finds that his own mortality in 345 cases was 4.9 per cent, and that of other operators is about the same. He considers the mortality of fibroid tumors, including that of their degenerations and complications, treated on the expectant plan, to be at least 33 1-3 per cent. He concludes his paper in the following words: "Believing that the best treatment of fibroid tumors in general is their early removal, the question remains whether there are no exceptions to the rule. The best answer to this is that each case must be decided upon its merits. It is my individual experience that small subperitoneal fibroids in women of 40 years of age or more are the least apt to grow and to cause serious symptoms. Conversely, submucous and intramural fibroids in younger women are the most apt to develop and to cause serious trouble.

It has been the writer's experience to meet with but few fibroids which were not producing symptoms and it is therefore my belief that the percentage of cases is small in which operations are not more often advisable than the expectant plan of treatment.

In reviewing the reports of Cullingworth, Frederick and Martin, it is conservatively estimated by them that upward of two-thirds of women having fibroid tumors will die if not subjected to operation. The contrast with the results which can be secured by operators is very striking. It probably will not be disputed that the mortality of myomectomy and hysterectomy is between 2 per cent and 10 per cent, depending upon the gravity of the case, upon the operator and upon the environment in which the operation was done. It seems a fair conclusion that the resort to early operation will effect a saving of 25 per cent to 30 per cent in mortality. It seems to me that the attitude of the text-books should be reversed, and that the rule of practice should be to remove all fibroids which come under observation, unless, in a particular case, there seems to be some good reason for temporizing, due either to the small size of the tumor, or to the advanced age, or to the poor general health of the patient.

Certainly no one can gainsay that whenever the disease causes displacement, hemorrhage, pain or pressure sufficient to threaten damage to the general health, to the nervous system or to the pelvic organs, the operation should be advised.

In arriving at a definite conclusion the indirect effect of these tumors must be taken into consideration, such as pressure upon the colon, upon the iliac veins or upon the ureters, causing ultimate intestinal, heart or kidney complications. A patient worn out from pain and anemic from loss of blood grows more and more into such a condition that she may contract almost any disease she would not have contracted otherwise, and having contracted it, is unable to survive on account of the general poor condition of her health. These indirect results are far more serious than the direct ones in uterine fibromas.

The writer believes that as the seriousness of the affection becomes better recognized, and as the ability for doing better work increases, the indications for operation will be so generally recognized that no surgeon's record should show that any of his cases have been sacrificed because they waited until it was forever too late.

Not infrequently in the course of a confinement a fibroid tumor of more or less size may be discovered which has never given rise to symptoms before, nor does it manifest any dangerous tendencies after labor. The mere fact that this tumor is discovered incidentally would not be a satisfactory indication for its immediate removal, but at the proper time subsequently a myomectomy or hysterectomy should be done.

The treatment of cases of pregnancy complicated by the presence of fibroid tumors has undergone quite a change in late years.

Archibald Doran sums up the condition as follows: "In the great majority of instances in which fibromyomata of the uterus and pregnancy co-exist, unless the tumor is large enough to make normal labor impossible, the course of the pregnancy and of the subsequent labor is not seriously influenced by the tumor; but in a small proportion of cases the patient's life and the life of the child are seriously endangered. When pregnancy is found to be complicated by a fibroid tumor, it is best to allow the pregnancy to go to term as long as the

mother's health is not seriously endangered. If, at the onset of labor, or shortly before, it seems certain that the tumor will cause obstruction to the birth of the child, Cesarian section, possibly followed by hysterectomy, should be performed. In cases in which the death of the child makes it necessary to interfere in the earlier months, abdominal section should be performed and an attempt made to enucleate the tumor. If under these circumstances myomectomy is found to be dangerous, hysterectomy should be performed."

The traditional view, and one of the chief arguments of the extreme conservative school, is that the great majority of fibroids cease to grow with the onset of the menopause. There is a growing tendency to discredit this view.

Landan says that the good effect generally attributed to the menopause is seen only in exceptional cases. Too often the presence of the fibroid postpones the cessation of menstruation indefinitely, so that metrorrhagia continuing, the operation has to be performed after all, but with less chance of success.

In most cases the diagnosis of fibromyomata is not difficult. So let us pass on to the indications for operation: 1, hemorrhage; 2, malodorous discharge; 3, pressure symptoms referable to the bladder, rectum, ureters or elsewhere; 4, pain; 5, rapid growth of the tumor, or 6, continuous dwelling by the patient upon the fact that she has a tumor. Occasionally a patient will become morbidly introspective, through dwelling upon the fact that she has a tumor. She continually worries about it and falls into a neurotic state, which in itself may demand the removal of the tumor to relieve the serious mental perturbation.

It seems to me that in fibromas of the uterus less advancement has been made in the direction of the preservation of the other pelvic organs than in that of any other body lesion. There is no question as to the advisability of conservative surgery in these cases. In young women in selected cases with a single uterine fibroid demanding removal, myomectomy should be the operation of choice. This operation is possible in a great many cases of fibroids where the tumor is small. In all possible cases one or both ovaries should be left intact and not removed. Convalescence is made more complete thereby and perfect ultimate recovery more positive.

Myomectomy preserves menstruation; myomectomy makes possible subsequent pregnancy in women under 40 years of age; myomectomy guards against artificial menopausal symptoms. But myomectomy, even if every visible and palpable tumor is removed, does not guard absolutely from recurrences as would hysterectomy; nor does myomectomy always relieve the suffering of the patient as does hysterectomy.

The following are some objections to myomectomy which have been urged by its opponents. The further growth and development of undiscovered nodules; the possibility of excessive hemorrhage during the operation; the possibility of hemorrhage into the bed of the tumor following operation, and the subsequent infection of the blood coagulum; air embolism from the bed of the tumor; weakness of the uterine wall after myomectomy predisposing to rupture of the uterus in a subsequent labor. The advantages of myomectomy over hysterectomy lay in the preservation of fecundity and in the continuance of the menstrual flow. Finally even in the face of the advantages and objections, myomectomy is the ideal operation, but only in selected cases.

In the absence of extensive adhesions and apparently insurmountable complications, these patients almost invariably recover.

In conclusion, after the decision is reached to operate on a fibroid tumor, interest centers in the variety and technique of the operation. It is much easier to perform a suprapubic hysterectomy than any other operation for the removal of these growths and likewise it is less difficult to remove the ovaries with the uterus than to conserve them. The writer personally prefers in selected cases myomectomy, remembering always that after submitting to such a serious operation, the patient has the right to be guaranteed against a second or third operation for the same condition. Therefore, when in doubt about the complete removal of all diseased tissues by myomectomy, by all means do the radical operation, a complete hysterectomy. So many women have been disappointed by these incomplete or so-called conservative operations that their friends who really could be cured by an operation hesitate to undergo it. Therefore, I repeat, when in doubt do a complete hysterectomy.

**THE USE OF QUININAE HYDROCHLORATE ET UREA IN  
½ TO 1 PER CENT SOLUTIONS AS A  
LOCAL ANALGESIC.\***

ALLEN E. COX, M.D.  
HELENA, ARK.

An agent that will produce complete analgesia to tissues when injected or when topically applied to mucous membranes without manifesting any of the deleterious or dangerous tendencies which most of our recognized agents of local analgesic fame possess has long been hoped for and very much desired. That cocaine hydrochlorate in very weak solution, especially when combined with adrenalin, as well as eucain B. and stovain, etc., fulfills the requirements of a local analgesic is well known to all of us. I know of some men doing a very large surgical work using local anesthesia whenever it is possible, which in their hands is quite often without any of the dangerous effects of these drugs having been manifested. Many of us, however, have had experiences that are not very pleasant to think of, and we know that death can and has resulted from their use. We have in quinine bisulphate and hydrochlorate with urea an agent possessing analgesic properties. Dr. Henry Thibault contributed a paper on this subject at the annual meeting of the Arkansas State Society, in 1906, which was the first time that I had heard any claim laid to the use of this drug for local anesthetic purposes. Dr. Thibault cited numerous experiments, many of which were made on his own person, demonstrating that this agent in weak solutions possessed local analgesic properties when injected into tissues. While my experience with this agent has been limited, yet when used in weak solutions ½ to 1 per cent after first boiling in normal saline solution and injected while warm into the tissues until the parts become somewhat indurated and even slightly blanched, analgesia has been complete in about five minutes and lasting from one to seven days. I can say that this method has proven satisfactory in my hands. I have

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\*Read before the twenty-seventh annual meeting of the Tri-State Medical Association of Mississippi, Arkansas and Tennessee, at Memphis, November 15, 16 and 17, 1910.

used it in about two dozen cases, covering local abscesses, ingrowing toe nails, circumcisions, hemorrhoids and fistula in ano, and in the latter I have found this method most satisfactory. In my opinion it is not suitable in operative work where the parts are to be approximated by sutures for the reason that a certain amount of induration always results which makes it difficult to accurately maintain perfect coaptation. As already mentioned, some of the most satisfactory work I have had was among the hemorrhoidal and fistula in ano cases; this perhaps is due to the fact that I have handled a greater number of this class of trouble.

I wish it understood that I am not claiming this means of local anesthesia as ideal, because it is not, for two reasons; one is, in too concentrated solutions or in excessive quantity suppuration might supervene—the other is the induration resulting; but where a general anesthetic is objectionable or impracticable on account of an organic lesion of heart, lungs or kidneys, or on account of senility and when the use of cocaine or eucain B. is objectionable for obvious reasons, this method of local anesthesia will enable us to reach a class of work that we would otherwise be unable to reach.

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#### **Superficial Knowledge Advocated.**

Dr. Sarah M. Siewers is quoted in the local papers as follows: "There is a great field for women in the medical profession, particularly in the newer schools, and if every girl studied one term in a medical college she would make a better and a wiser mother."

It would be a case of a "little knowledge is a dangerous thing." Every physician has met nurses with a smattering of medical knowledge which gave the possessors nothing save a distorted view of their own accomplishments. The "newer schools," which presumably includes osteopathy, would be no more competent to give women a liberal culture in the medical sciences in one term than the older. If women elect to finish a course in medicine, after being properly qualified, they may possibly become better mothers and greater leaders in humanitarian movements. But a smattering of knowledge would be worse than useless. Dr. Siewers is spreading a pernicious doctrine.—Cincinnati Lancet-Clinic.

## PROGRESS OF MEDICINE.

### MEDICINE.

In Charge of BRYCE W. FONTAINE, M.D.  
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#### Albumin in the Urine of Normal Children.

In each specimen of urine, Hamil and Blackfan determined the color, the appearance, the specific gravity, the reaction (in twenty-four-hour specimens, the total acidity), the presence or absence of albumin, sugar, acetone, diacetic acid, indican, urobiligen and phenol; and microscopically the presence or absence of cells, casts, cylindroids and crystals.

Four hundred and forty-five specimens were examined. These were obtained from 124 children, ranging in age from 18 months to 14 years. During the period of examination the usual routine of life was followed, except that the children were kept from school.

There was no relationship between the specific gravity and the form or amount of albumin. Sugar, acetone and diacetic acid were never found. They may, therefore, be considered as having no bearing on the production of albumin. Indican, phenol and urobiligen, when present, were usually associated with albumin, but albumin was sometimes absent when they were all present, and the amount was never greater when associated with them than it was in the cases in which they were absent.

Crystals, when present in amounts such as are occasionally found in normal children are in no way responsible for the associated albumin. The mild disturbances of the intestinal digestion, as shown by the examination of the stools, were not sufficient to account for the occurrence of albumin.

The blood pressure was within the normal range in all cases and, therefore, did not influence the albumin output. The albumin elimination was the same on mixed and exclusive milk diets. They found no children in whom the albumin excretion corresponded to the requirements for postural or orthostatic albuminuria, a rather surprising result in view of the frequency with which this condition is supposed to occur.

Thirty-two and a half per cent of the children showed occasional hyaline casts and cylindroids in the urine. The authors do not consider their "occasional presence" as indicative of a lesion of the kidneys, but rather as suggesting a temporary overtaxation of the kidneys resulting from variations in the habits of life of the individuals, which are too slight to be recognized.

Eighty-eight and seven-tenths per cent of the urine of these 124 children showed albumin, 27.4 per cent showed serum-albumin alone and in combination, and 85.4 per cent showed an albuminous body precipitated by acetic acid in the cold. These two albumins were nearly always present in very slight traces, occasionally in slight traces and rarely in traces.

In 38 children the 24-hour specimens showed nucleo-albumin in all but one, and in this case samples examined over prolonged periods of time showed nucleo-albumin frequently. In these 38 children, the percentage of serum-albumin was very much larger (42.1 per cent.) than in the total number of cases examined.

The authors believe, therefore, that it is possible to demonstrate in the urine of every presumably healthy child traces of an albuminous body precipitated by acetic acid. Consequently, this substance must be regarded as an exceedingly common, if not constant, manifestation in the urine of children under 14 years of age, and as of no clinical significance.

Hamil and Blackfan do not believe that serum-albumin in the amounts in which it appears in these children indicates a diseased condition of the kidneys any more than does the presence of occasional hyaline casts and cylindroids, and that its etiology may be considered the same as that given for these former elements.

#### **Subacute Infective Endocarditis.**

Subacute infective endocarditis is a condition long recognizable by clinicians through certain signs and symptoms; the isolation of the infectious agent from the blood in order to clinch the diagnosis, is as yet a method of examination too seldom used.

The disease is insidious in onset and may develop in any one of several ways. Thus one patient may suffer from dyspnea, with or without precordial distress, general weakness, emacia-

tion, vague pains, cough or arthralgia; another may present a condition simulating subacute rheumatic fever and often indistinguishable from it; or a third may have fever, often unexplained by physical examination.

Clinically, the manifestations of this type of endocardial disease may include (1) signs of valvular disease, usually present, but occasionally lacking; (2) fever, often slight, at times high and intermittent, always irregular, with or without chills; (3) malaise, gastric disturbances, weakness and emaciation; (4) anemia, usually of marked degree, with a peculiar earthy pallor of the skin; (5) splenomegaly, ostealgia and arthralgia, joint swellings and, as Libman has pointed out, tenderness over the gladiolus sterni.

Embolie aneurysms are common. Painful erythematous nodules—the “*nodosites cutanees éphémères*” of the French—are sometimes present. Petechiae are common and hematuria is not a rare complication.

The disease is more often noted among private patients than in hospital practice. Its duration varies from two months to one and one-half years and is almost invariably fatal.

According to Horder, infective endocarditis is pre-eminently a form of streptococcal disease, for streptococci occur in 66 per cent of the cases. The organism isolated by him, however, was not the ordinary virulent *streptococcus pyogenes*, but a form more nearly allied to the more saprophytic streptococci of the alimentary tract—*streptococcus salivarius*, etc.

More recently, Rosenow and Libman and Celler have studied the blood of patients with subacute infectious endocarditis and have isolated the organisms whose presence they consider of diagnostic import.

In 36 of the 43 cases studied by Libman and Celler blood cultures were made. In 35 of these they found atypical “*endocarditis cocci*,” which were gram-positive, round, ovoid or bacillary in form, occurring in clusters, in pairs or in chains, never encapsulated. These cocci are smaller than ordinary streptococci or pneumococci and grow more feebly. In the original cultures from the blood, growth was noted first after 48 hours, rarely as early as 24 hours, often not until after five or six days.

On agar, a feeble translucent growth appears, adherent to the surface of the medium, a characteristic lost in subcultures. On blood-agar plates a definite clear zone is sometimes, though rarely seen, usually taking two to four days to develop. In transplantations this is lost. Colonies in the original plates are usually white in color, with or without a green or opaque zone about them. In subsequent cultures on blood-plates three types of growths are seen. There may be a production of green pigment, there may be a moist white growth, or a dry almost colorless, very slight growth. They are not dissolved by bile. About one-third of the strains ferment inulin. All strains precipitate or whiten serum-glucose agar.

The endocarditis cocci are not very pathogenic for mice, though peritonitis and endocarditis have been produced by them.

The attenuated nature of these atypical cocci—whether they be pneumococci, as Rosenow and Billings regard them, or streptococci, as Libman and Celler and Schottmuller class them—agrees with the course of the disease and may serve to explain several of its striking features, including: (a) the chronicity in many cases and the latency of the malady in others; (b) the slight grade or entire absence of leucocytosis is often seen; (c) the afebrile periods which are common and the occasional absence of fever altogether; (d) the absence of suppuration in the infarcts; (e) the enormous numbers of the cocci that may be present in the blood-stream without causing grave symptoms.

These endocarditis cocci do not appear to be specific, though they have never been found in other conditions. The discovery of them gave rise to the hope of an antiserum or of a vaccine therapy, but so far treatment along such lines has been without favorable result. In fact, according to Rosenow, vaccine therapy may even prove harmful. Now that a more acute knowledge of the disease has been reached, and the etiology cleared up, the dawn of a rational therapy would seem to be near.

#### **Rest in Bed in Angina Pectoris.**

At a meeting of the "Academie de Medicine of Paris," on November 29, M. Ch. Fiessinger presented an elaborate study

of the effect of rest in bed in angina pectoris, due to organic diseases (in which the attacks are always produced by exertion).

The late M. Huchard has insisted on the value of reducing the blood-pressure in angina pectoris, the crises of which are liable to be accompanied by increased blood-pressure. M. Fiessinger pointed out that rest in bed not only lowers blood-pressure, but acts as a tonic to the heart and diminishes its irritability. What part is played by these different factors? In his cases he found four different conditions: 1. The blood-pressure during the pain was normal or low and was not modified by rest in bed. 2. The pressure during the attack was raised was not modified by rest in bed. These two classes form only a minority of the cases. 3. The pressure was high and was lowered by rest in bed; this held for two-thirds of the cases. 4. In exceptional cases the pressure was not lowered, but even rose, and curiously, this was not accompanied by increase of the pain.

In the first class three patients were seen. An example was a man, aged 66 years, who had an aortic systolic murmur and showed only slight acceleration of the pulse on walking. An attack of angina pectoris followed the exertion of putting to bed a sick relative. The maximum blood-pressure with Pachon's sphygmometer was 17 centimeters of mercury and remained the same after rest in bed, which caused the symptoms to disappear.

In the second class three patients in the "sixties" suffering from atheroma with aortic disease were seen. The maximum pressure varied from 17 to 24 and was not modified by rest in bed. Yet the pain was much diminished, a proof that it was not the arterial tension which caused the pain.

In the third class 11 patients were seen. Thus, a man aged 64 years, had a maximum pressure of 28 during an attack. Under rest in bed, ice to the precordium, milk diet and morphine injections, the pressure was reduced to 19. Eight patients showed reduction of pressure of from 2 to 4 centimeters of mercury with great relief. In the fourth class, in which a high blood-pressure was not lowered by rest in bed, the effect on pain was variable; in some cases it was considerably relieved, in others only slightly.

M. Fiessinger concludes that the part played by high blood-pressure in angina pectoris has been exaggerated, and that this condition no more produces the crises than it does those of biliary colic or puerperal eclampsia. Rest in bed relieves the subjects of angina pectoris, but only partly by its effects on the blood-pressure. To give full results rest in bed must be prolonged to six weeks, and even to two months when the patient can not take a step without pain.

A milk diet should be ordered, later, farinaceous foods may be added. The usual drugs (theobromine, trinitrine, morphine and digitalin) are given at the same time. But nothing has such a certain and rapid action as rest in bed. Recourse should be had to it again if after a period of immunity the symptoms recur.

The greatest relief is obtained in aged patients or in those who lose flesh during the treatment; the least in patients suffering from concomitant aortic insufficiency.

#### **Sudden Onset of Enteric Fever by Hemorrhagic Nephritis.**

Acute hemorrhagic nephritis is a rare complication of enteric fever; still rarer are cases in which the onset of the disease is marked by this complication and the eruption occurs later. An example was reported at the meeting of the "Societe Medicale des Hopitaux" of Paris, on December 2, 1910, by M. A. Pissavy and M. Gauchery.

On September 7, a youth, aged 18 years, was admitted into the Pitie Hospital with all the symptoms of acute hemorrhagic nephritis. The urine was of normal quantity, but of a blackish red color, and contained a large quantity of albumin. Microscopic examination showed granular and blood casts and deformed red blood corpuscles. There were also intense headache, a dicrotic pulse of 100, a temperature of 104, bronchitic rales, furred tongue, constipation, enlarged spleen and edema of the lower limbs. The history was that eight days previously the symptoms began suddenly after a chill. The dicrotic pulse, the want of correspondence between the pulse and the temperature, and the splenic enlargement should have suggested the diagnosis of the renal form of enteric fever, but this possibly was not considered.

On September 14, rose spots appeared, diarrhea replaced the constipation and Widal's reaction was positive in a dilution of 1 in 50. From the 15th to the 20th the amount of blood in the urine in proportion began to diminish. On October 5 the temperature reached normal, the urine was clear, and the quantity of albumin had fallen to half a grammme per liter. On the 9th the patient was discharged, and his urine contained a quarter of a grammme of albumin per liter.

M. Pissavy and M. Gauchery have found recorded five similar cases in the "Theses de Paris." In the first, a man aged 24 years, after a chill had to take to bed with headache and fever. When taken to the hospital a week later, he had a temperature of 102.2, a pulse of 90, a puffy face and bloody and highly albuminous urine.

The appearance 48 hours later of rose spots allowed the diagnosis of acute nephritis to be revived. Recovery ensued.

In the second case, a man aged 37 years, was taken to the hospital in a state of profound stupor, with a temperature of 102.8, a pulse of 98, and an enlarged spleen. The urine was scanty and highly albuminous. He had been ill for ten days. On the day after admission the urine was suppressed. Jaborandi was given and produced sufficient diuresis, but the urine was bloody. Five days later rose spots appeared. After three weeks the patient was discharged, the urine containing only a trace of albumin.

In the third case, a woman, aged 20 years, was suddenly attacked with headache, nausea, giddiness, oliguria and hematuria. The urine contained much albumin. After eight days rose spots appeared and her condition became much worse. She died on the fortieth day. At the necropsy the kidneys were found very large and congested.

In the fourth case, a woman aged 21 years, was seized with headache, backache, vomiting and diarrhea. Five days later she was admitted into the hospital in a high state of fever. The urine was scanty and contained a large quantity of albumin. Three days later it became bloody and rose spots appeared. Death occurred on the eighth day of the fever. As in the previous cases the kidneys were found enlarged and congested.

In the fifth case, a man, aged 21 years, was admitted into the hospital on the fifth day of a severe fever. Forty-eight hours after the onset he noticed that the urine was blackish. On admission the urine contained blood, a large quantity of albumin, and numerous casts. The temperature was 103.5 and the pulse was 101. The liver and spleen were enlarged; and there was gurgling in the right iliac fossa. Death occurred on the 13th day of the typhoid fever.

These cases show several noteworthy points. The first is the suddenness of onset of the renal symptoms. The second is the prognostic importance of the amount of urine secreted. In two of the three fatal cases there was persistent oliguria; in the other case the quantity of urine secreted is not stated. On the other hand, in the present case the amount of urine secreted was always satisfactory, and in the second case quoted there was only temporary oliguria. But the prognosis of this form of typhoid fever is grave; the six cases show a mortality of 50 per cent. In all the cases the cause of the nephritis seems to have been overlooked until the appearance of the rose spots, although it should have been suspected in consequence of two symptoms—enlargement of the spleen and want of correspondence between the temperature and the pulse. The former was about 104, while the latter was only about 90 to 100.

#### **Magnesium Sulphate in Erysipelas.**

Four cases are reported by Choksy in which the immediate effects of the application of magnesium sulphate solution were extremely beneficial. Pain and swelling abated, fever decreased, and extension of the disease was controlled in the majority of cases. A saturated solution of magnesium sulphate in water (preferably strained through muslin) was applied around the limb or on the face as a mask, extending well beyond the inflamed area, in from 10 to 15 layers of gauze or a thin layer of absorbent cotton or lint, and covered with oiled silk or wax paper.

The dressing should be wetted as frequently as it gets dry, about once in two hours. It should be removed once in twelve hours for inspection and immediately re-applied. The affected area should not be washed during treatment.

**OPHTHALMOLOGY.**

In Charge of ARCHIBALD C. LEWIS, M.D.

Clinical Instructor in Ophthalmology, Otology and Laryngology in the Memphis Hospital Medical College.

**The Value of Old Tuberculin in Determining the Etiology of Optic Neuritis and in the Treatment of It.**

Gamble, Wm. E., Chicago (The Ophthalmic Record, February, 1911), describes two cases of optic neuritis and tubercular neuro-retinitis in which an obscure etiology was cleared up by a subcutaneous diagnostic dose of old tuberculin. In both of these he effected a complete cure through the administration of therapeutic doses of tuberculin continued for several months.

Before resorting to the tuberculin test Gamble obtained a negative Wasserman and urine examination and eliminated the more common causes of these conditions.

In the first case he gave a diagnostic dose of four mg. old tuberculin subcutaneously. Reaction occurred seventeen hours after the injection with considerable systemic disturbance, such as restlessness, exhaustion, anorexia, general aching throughout the body and two degrees of temperature. The eyes ached severely and developed marked tenderness on pressure. During the reaction both the near and distant vision were greatly reduced.

Gamble says that when he began giving the patient therapeutic doses the vision in his right eye was only 8/200. He began with 1/500 mg. tuberculin T. R., gradually increasing it to 1/30 mg. during six months' time, when the vision had risen to 20/15. There still remained some disturbance in the perception of colors, however.

In the author's second case, which he calls "Tuberculous Neuro-Retinitis," and which also occurred in a physician, the symptoms and the reaction, the treatment and the course of the disease were very similar to the case described above.

He further remarks as follows. "The pronounced reduction in sight occurring about 17 hours after the diagnostic dose is given and lasting about four days is the symptom of chief importance, and to my mind makes out definitely a case of tuber-

culous disease involving the optic nerve or tracts in the region of the chiasm and must be considered in the nature of a specific reaction, and, in view of this diagnosis, the great value of tuberculin T. R. in small doses is shown.

#### **Keratomalacia.**

This is a condition occurring in marasmic babies and characterized by infiltration, ulceration, perforation and cicatrization of the cornea and usually terminating in blindness in the affected eye. In about half the cases both eyes are affected. It is rarely seen in this country, and when it is found is usually in the improperly fed negro baby.

Stevenson, Sydney, London, England (*Annals of Ophthalmology*, January, 1911), presents an exhaustive article entitled "On Sloughing Cornea in Infants; an Account Based upon the Records of 31 Cases." In each one of these cases he gives the complete history treatment and progress as well as the pathological findings where the patients died and post-mortem was obtained.

Various causes of this malady are ascribed by different writers. Among them are mentioned encephalitis, diarrhea, improper and insufficient food, acute jaundice and generalized bacterial invasion. Stevenson says that all available evidence goes to show that the determining cause of the corneal ulceration is to be found in exogenous micro-organism, while its predisposing cause is the lowered vitality of the patient. The predisposing cause would probably be inadequate without the exciting cause, and vice-versa. The disease seldom occurs in breast-fed babies.

The child presents the usual symptoms of marasmus—progressive wasting, lax and withered skin, anemia, characteristic look, subnormal temperature and a marked tendency to diarrhea and vomiting. If the nutrition cannot be improved the cornea is likely to perforate. This is succeeded by escape of the aqueous and vitreous humors and the crystalline lens. The globe eventually shrivels up into a small, white, sightless mass.

In closing Stevenson draws the following conclusions:

1. Keratomalacia in young children is known to occur in practically every country, the scientific records of which are available for inspection.

2. It affects children whose ages usually range from three to twenty months, and is especially frequent at about the eighth month of life.
3. It occurs chiefly in the children of the poorer classes.
4. It affects both eyes in about one-half of the babies.
5. It is associated with xerosis conjunctivæ in about 50 per cent of the cases.
6. It occurs only in babies whose vitality has been seriously reduced by "epidemic" or "zymotic enteritis," congenital syphilis, athrepsia or tuberculosis, named in their order of frequency.
7. Its mortality amounts to about 50 per cent of those affected. The immediate cause of death is usually broncho-pneumonia or exhaustion.
8. It leads to blindness in about one-half of the children who survive.
9. It is associated with no specific micro-organism, although in scrapings from the cornea the pneumococcus may be found in about one-half of the cases.

#### **Cryptophthalmia.**

Eberhardt, Michigan City, Ind. (*The Ophthalmic Record*, January, 1911), adds another case of this interesting condition to the comparatively few already reported. He saw the baby on the day of its birth, and says: "The child, female, born at term, was perfectly well developed with the exception of deformed left concha and total bilateral symblepharon. The skin extended on both sides uninterruptedly from the supra-orbital to the infraorbital ridge over spherical prominences which were undoubtedly eyeballs. Eyebrows were present, but no eyelashes at all. There existed on both sides a very faint depressed line, corresponding to the place where the separation of upper and lower lids should have taken place."

An exploratory operation was done without anesthesia to ascertain whether or not the eyeballs had any functional value. There was no trace of pupil or fundus reflex to be found, and the operation was without result except from a cosmetic point of view. It is interesting to note that the parents of the child were first cousins and that a brother and a sister of the patient were both unsound, the latter presenting congenital abnormalities very similar to the ones described.

**Ophthalmic Studies in Chronic Interstitial Nephritis.**

Peter, L. C., Philadelphia, Pa. (New York Medical Journal, August, 1910), arrives at the following conclusions after observing a number of cases:

1. Increased blood pressure is probably the chief cause of eye changes found in chronic interstitial nephritis.
2. Defective elimination may also play a part in their production, but is more closely related to the toxic symptoms of the eye.
3. Eye phenomena are an aid to diagnosis and prognosis in the form of chronic Bright's disease.
4. In order to prevent, if possible, the more serious forms of eye changes, an early diagnosis is necessary.

In diseases involving the renal and arterial systems, a joint study by internist and ophthalmologist is productive of the greatest amount of good to the patient and to the physician.

**Cataract Operation.**

"Beneath his wrist there stirs a sun-god's thought.  
A strong magnetic current swiftly flows  
Through palm and finger-tip and power bestows  
On tiny blade of steel, with promise fraught.  
Up toward the eye the charged blade is brought.  
Marble, moonlit, the arched cornea shows,  
The iris, lying lakelike in repose,  
And the deep pupil where the soul is caught.  
'Let there be light,' he says—'Let there be light,'  
And solemn as the sign of cross, the hand  
Performs the miracle. At that command  
The pulsing thought leaps toward the blind man's night,  
Symbolic, like a dove's flight to its nest,  
The haloed hand drops down and is at rest."

Mary Murdoch Mason in *The Doctor's Factotum*.

## SOCIETY PROCEEDINGS.

### **The West Tennessee Medical and Surgical Association.**

The twentieth annual meeting of the West Tennessee Medical and Surgical Association will be held at Dyersburg, Tenn., May 10, 11 and 12, 1911.

This association was organized at Humboldt, Tenn., May 26, 1892. The following list of members will show how the association has prospered:

#### **Roll of Members of West Tennessee Medical and Surgical Association.**

ADM.	NAME.	P. O. ADDRESS.	COLLEGE.	DATE GRAD.
1897	Allbright, J. A.	Somerville	Cl. P. & S., Balt.	1882
1908	Allen, J. W.	Rutherford	Univ. Nashville.	1900
1893	Allen, J. T.	Brownsville	Bellvue, N. Y.	1880
1899	Adkisson, J. D.	Medina	Univ. Tennessee	1898
1906	Andrews, J. L.	Memphis	Mem. Hosp. M. C.	1895
1896	Arnold, J. M.	Lexington	Vanderbilt	1890
1899	Arnold, J. M.	Jackson	Vanderbilt	1878
1896	Barbee, J. T.	Jackson	Bellvue, N. Y.	1896
1908	Barr, R. A.	Nashville	Vanderbilt	1894
1909	Barksdale, J. W., Hon.	Vaiden, Miss.	Birmingham M. C.	1899
1893	Biggs, V. A.	Martin	Vanderbilt	1884
1910	Black, W. T.	Memphis	Mem. Hos. M. Col.	1898
1897	Blackmon, J. A., ex-Pres.	Jackson	Vanderbilt	1883
1910	Blanton, M. A.	Union City	Vanderbilt	1903
1893	Boothe, S. D.	Maury City	Louisville Univ.	1893
1904	Bradfield, D. W.	Wildersville	Univ. Nash.	1902
1895	Bradford, J. A.	Curve	Vanderbilt	1891
1895	Brassfield, S. W.	Crockett Mills	L.	1893
1910	Brasher, G. W.	Sugar Tree	Univ. Tenn.	1909
1904	Bryant, G. C.	McLemoresville	Mem. Hosp. M. C.	1903
1910	Buford, G. G.	Memphis	Vanderbilt	1880
1895	Bouton, L. G.	Saulsbury	Vanderbilt	1881
1892	Callis, G. W.	.....	Mem. H. M. Col.	1885
1892	Caldwell, J. K. P.	Jackson	Louisville Univ.	1881
1892	Carroll, J. R.	Henderson	Univ. Nashville	1875
1909	Carter, J. H.	Memphis	Mem. Hosp. M. C.	1905
1908	Clark, A. H.	Whitthorne	Vanderbilt	1883
1909	Clary, W. F.	Memphis	Vanderbilt	1903
1903	Clopton, A. T.	Milan	Vanderbilt	1902
1896	Cock, W. S.	Bolivar	Mem. Hos. M. Col.	1889
1904	Coffman, R. J.	Whiteville	Louisville Univ.	1889

ADM.	NAME.	P. O. ADDRESS.	COLLEGE.	DATE GRAD.
1902	Cole, J. D.	Newbern	Vanderbilt	1884
1894	Connell, W. H.	Hot Spgs., Ark.	Lebanon, O.	1889
1910	Cochran, T. N.	Trenton	Vanderbilt	1906
1902	Cox, J. B.	Huntingdon	Univ. Nashville	1878
1892	Craig, T. H.	Halls	Mem. Hos. M. Col.	1891
1904	Crisler, J. A.	Memphis	Mem. Hos. M. Col.	1890
1892	Crofford, T. J.	Memphis	Louisville M. C.	1876
1892	Crook, J. A., ex-Pres.	Jackson	Jeff. Med Col.	1870
1894	Crook, J. L., ex-Pres.	Jackson	Vanderbilt	1894
1892	Crutcher, J. R.	Memphis	Vanderbilt	1882
1908	Curry, J. M.	Toone	Mem. Hosp. M. C.	1907
1908	Cottenger, C. M.	Teague	Mem. Hosp. M. C.	1906
1907	Dancey, A. B.	Jackson	Vanderbilt	1902
1908	Davis, R. B.	Memphis	Vanderbilt	1900
1904	Dennison, A. I.	Atwood	Mem. Hos. M. Col.	1904
1908	Donaldson, A. A.	Brazil	Mem. Hos. M. Col.	1903
1899	Drake, C. C.	Jackson	Univ. Nashville	1898
1902	Duckworth, W. C.	Jackson	Vanderbilt	1900
1910	Dulaney, O.	Dyersburg	Univ. Nashville	1901
1908	Dickerson, R. C.	Brownsville		
1898	Dorris, G. M.	Bolivar	Univ. Tenn.	1880
1907	Bentley, C. C.	Kerrville		
1892	Faucett, J. T.	Trenton	Vanderbilt	1881
1909	Faucett, P. F.	Trenton	Barnes Univ., Mo.	1908
1895	Fletcher, R. S.	Hon. Lay Member on account of interest in the Society.		
1870	Fowlkes, J. A.	Dyersburg	Univ. Nashville	1870
1890	Fullerton, H. T.	Kenton	Mo. Med. Col.	1867
1892	Gillespie, G. B.	Covington	Vanderbilt	1875
1897	Goltzman, M.	Memphis	B. U., Canada	1892
1894	Greer, R. L.	Norwood	Vanderbilt	1890
1898	Gresham, J. W.	Jackson	Ky. Sch. Med.	1895
1900	Griffin, R. W.	Tiptonville	Tulane Univ.	1894
1895	Griffin, J. F.	Tiptonville	Vanderbilt	1890
1896	Haggard, W. D.	Nashville	Univ. Tennessee	1893
1896	Hamilton, F. B. Jr.	Jackson	Univ. Nashville	1895
1895	Hannah, J. H.	Covington	Mem. H. M. Col.	1895
1910	Harwood, Thos.	Trenton	Vanderbilt	1906
1899	Harris, J. H.	Bells	Vanderbilt	1895
1900	Hawkins, H., ex-Pres.	Jackson	Vanderbilt	1889
1907	Hearn, J. F.	Pinson		1889
1907	Hanley, C. A.	Jackson		1907
1892	Henderson, S. A.	Jackson	Vanderbilt	1884
1892	Henning, B. G.	Memphis	Bellvue, N. Y.	1870
1907	Henning, D. M.	Memphis	Col. P. & S., N. Y.	1902
1894	Herron, J. T.	Jackson	Jeff. Med. Col.	1884
1892	Hill, J. F.	Memphis	Mem. H. M. Col.	1887

*The West Tennessee Medical and Surgical Association*

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ADM.	NAME.	P. O. ADDRESS.	COLLEGE.	DATE GRAD.
1910	Holland, W. W.	Dyersburg	Univ. Nashville	1909
1899	Holder, E. M.	Memphis	Mem. H. M. Col.	1894
1899	Hopper, J. D.	Jackson	Ky. Sch. Med.	1892
1905	Hudson, D. A.	Malesus	Mem. H. M. Col.	1900
1907	Huffman, S. W.	McKenzie	Univ. Tennessee	1906
1900	Howard, J. A.	McConnell	Univ. Tennessee	1900
1898	Hornsby, I. H.	Whiteville	Mem. H. M. Col.	1885
1904	Huntsman, W. F.	Juno	Univ. Tennessee	1899
1909	Jacobs, A. G.	Memphis	Univ. Virginia	1897
1892	Jackson, J. A.	Dyer	Louisville Univ.	1889
1902	James, G. W.	Humboldt	Univ. Nashville	1867
1910	James, F. C.	Gadsden	Ky. University	1903
1903	Jernigan, V. J.	Obion	Vanderbilt	1900
1898	Johnston, O. H.	Lexington	Vanderbilt	1891
1897	Jones, F. A., ex-Pres.	Memphis	Louisville M. Col.	1890
1907	Jones, H. L.	Jackson	Univ. Nashville	1901
1892	Jones, J. T., ex-Pres.	Jackson	Washington Univ.	1870
1908	Lane, W. G.	Jackson		
1904	Keeton, W. B.	Scott's Hill	Vanderbilt	1895
1892	Koffman, J. N.	Trenton	Univ. Nashville	1881
1893	Krauss, Wm., ex-Pres.	Memphis	Mem. H. M. Col.	1881
1896	Lacy, George	Medon	Louisville Univ.	1873
1908	Laster, B. F.	Jacks Creek	Univ. Tennessee	1890
1907	Lawrence, W. S.	Memphis	Vanderbilt	1900
1908	Liles, B. B.	Bargerton		
1900	Leroy, Louis	Memphis	Med. Chi. Col., Pa.	1896
1897	Lusk, P. B.	Jackson	Tulane	1894
1892	Love, C. T.	Alamo	Vanderbilt	1894
1904	Malone, B.	Memphis	Mem. Hosp. M. C.	1899
1909	Martin, E. H. Hon.	Hot Spgs, Ark.	Ohio Med. Col.	1887
1895	Mason, W. M., ex-Pres.	Hazel, Ky.	Louisville Univ.	1875
1902	Mason, Will Jr.	Murray, Ky.	Vanderbilt	1899
1910	Matthews, E. C.	Fruitland	Vanderbilt	1906
1895	Maury, R. B., ex-Pres.	Memphis	Univ. Virginia	1857
1895	Maury, J. M.	Memphis	Univ. Pennsylvania	1890
1907	Mays, T. B.	Pinson	Mem. H. M. Col.	1892
1907	Medling, W. L.	Dyer	Vanderbilt	1904
1906	Medling, W. T.	Dyer	Univ. Nashville	1874
1892	Minor, J. L.	Memphis	Univ. Virginia	1876
1892	Miller, A. H.	Paris	Vanderbilt	1882
1904	Mitchell, W. W.	Greenfield	Univ. Tennessee	1898
1910	Moody, A. H.	Dyersburg	Mem. H. M. Col.	1904
1900	Moore, Alfred	Memphis	Mem. H. M. Col.	1895
1892	Moore, J. C.	Laneview	Jeff. Med. Col.	1881
1891	Moore, M.	Memphis	Mem. H. M. Col.	1898
1906	Mulherron, E. R.	Ripley, R. F. D.	Univ. Tennessee	1905
1904	Mulherron, G. C.	Ripley, R. F. D.	Mem. H. M. Col.	1901

ADM.	NAME.	P. O. ADDRESS.	COLLEGE.	DATE GRAD.
1907	Murray, R. M.	Tresevant	Vanderbilt	1881
1905	McCown, O. S.	Memphis	Mem. Hosp. M. C.	1900
1893	McCoy, A.	Jackson	Jeff. Med. Col.	1888
1909	McCree, W. C.	Trenton	Vanderbilt	1907
1910	McDavid, W. P.	Dyersburg	Mem. Hosp. M. C.	1910
1910	McElroy, J. B.	Memphis	P. & S., Baltimore	1893
1907	McFall, R. J. Hon.	Cumberland City	Vanderbilt	1892
1902	McGannon, M. C. Hon.	Nashville	McGill Univ.	1885
1908	McDonald, S. E.	Bells	Vanderbilt	1904
1896	McKinney, R. B.	Memphis	Mem. Hosp. M. C.	1894
1897	McNeal, E. K.	Jackson	Columbia Univ.	1894
1897	McKinney, P. H.	Jackson	Louisville Univ.	1889
1892	McSwain, L. A.	Paris	Vanderbilt	1889
1896	McSwain, J. H.	Paris	Vanderbilt	1896
1898	Neeley, J. J.	Bolivar	Bellvue, N. Y.	1892
1893	Nelson, J. R.	Whiteville	Tulane Univ.	1882
1907	Nelson, R. B.	Jackson	Vanderbilt	1893
1907	Newman, R. L.	Dyer	Univ. Tennessee	1907
1907	Oliver, G. W.	Medina	Univ. Tennessee	1900
1897	Pearce, D. M.	Union City	Bellvue, N. Y.	1870
1896	Paris, J. C.	Kenton	Louisville M. C.	1879
1899	Penn, G. W., ex-Pres.	Humboldt	Vanderbilt	1884
1903	Penn, B. S.	Humboldt	Vanderbilt	1893
1899	Perkins, I. W.	Jackson	Vanderbilt	1882
1900	Perkins, I. E.	Jackson	Vanderbilt	1891
1910	Perry, R. J.	Manleyville	Univ. South	1906
1909	Pettey, G. E.	Memphis	Mem. Hos. M. Col.	1888
1896	Porter, O. J. Hon.	Columbia	Univ. Nashville	1890
1896	Porter, J. A.	Ripley	Vanderbilt	1894
1909	Preston, J. H.	Humboldt	Vanderbilt	1879
1895	Raines, J. T.	Malesus	Louisville Univ.	1874
1908	Raines, J. T. Jr.	Malesus	Mem. Hosp. M. C.	1906
1892	Rawlins, J. S., ex-Pres.	Danceyville	Univ. Pennsylvania	1867
1904	Raymond, F. S.	Memphis	Louisville M. C.	1875
1897	Reigh, Abe	Whiteville	Mem. Hos. M. Col.	1853
1906	Rice, J. C.	Braden	M. Hosp. M. C.	1902
1899	Richardson, J. J.	Milan	Louisville Univ.	1866
1892	Rochelle, W. F.	Jackson	Louisville Univ.	1883
1896	Roberts, W. F.	Troy	Univ. Tennessee	1894
1892	Rogers, W. B.	Memphis	Bellvue, N. Y.	1878
1908	Rosamond, Eugene	Memphis	Louisville M. C.	1902
1904	Rozzell, J. H.	Gibson	Univ. Tennessee	1902
1907	Rucker, S. T.	Memphis	Univ. Nashville	1898
1892	Saunders, J. T.	Blytheville, Ark.	Rush Med. Col.	1889
1902	Sasser, J. D.	Middleton	Louisville Univ.	1884
1896	Savage, G. C.	Nashville	Jeff. Med. Col.	1878
1902	Scates, D. W.	Martin	Jeff. Med. Col.	1879

ADM.	NAME.	P. O. ADDRESS.	COLLEGE.	DATE GRAD.
1808	Sanders, W. G.	Jackson	Vanderbilt	1907
1892	Sebastian, C. M.	Martin	Louisville Univ.	1870
1908	Seymore, J. T.	Eurekaton	Mem. H. M. Col.	1908
1907	Siler, M. E.	Mercer	Mem. H. M. Col.	1907
1897	Siler, M. J.	Mercer	Louisville Univ.	1889
1901	Siler, W. H.	Montezuma	Mem. H. M. Col.	1896
1896	Sinclair, A. G.	Memphis	P. & S., N. Y.	1886
1910	Sharber, A. R. Hon.	Nashville	Univ. Tennessee	1904
1904	Smith, J. L.	Ellbridge	Vanderbilt	1904
1903	Smith, L. C.	Milledgeville		
1895	Smythe, F. D., ex-Pres.	Memphis	Tulane Univ.	1891
1907	Snipes, J. J.	Memphis	Tulane Univ.	1906
1892	Steeley, R. B.	Buchanan	Louisville Univ.	1886
1899	Stinson, J. C.	Center Point	Vanderbilt	1882
1906	Summers, W. L.	Dyersburg	Col. P. & S., Mem.	1907
1897	Swink, W. T.	Milan	Vanderbilt	1900
1898	Tate, R. W., ex-Pres.	Bolivar	Col. P. & S., N. Y.	1895
1910	Taylor, W. W.	Memphis	Bellvue, N. Y.	1876
1898	Taylor, T. F.	Eaton	Vanderbilt	1897
1899	Thomas, G. R.	Jones		
1910	Thompson, Sid	Humboldt	Vanderbilt	1882
1901	Todd, J. D.	McKenzie	Vanderbilt	1889
1910	Toombs, R. S.	Memphis	Washington Univ.	1868
1892	Travis, A. E.	Como	Louisville Univ.	1881
1907	Tullos, A. M.	Gadsden	Univ. South	1901
1908	Turner, A. E.	Newbern	Univ. Pennsylvania	1874
1892	Turner, B. F., ex-Pres.	Memphis	Col. P. & S., N. Y.	1890
1900	Tyree, C. E.	Trenton	Vanderbilt	1880
1908	Troutt, J. M.	Jackson	Vanderbilt	1906
1901	Walker, D. A., Pres.	Trenton	Vanderbilt	1880
1892	Walker, J. L.	Paris	Vanderbilt	1861
1910	Walker, N. S.	Dyersburg	Tulane Univ.	1890
1892	Warterfield, A. P.	Memphis	Univ. Tennessee	1858
1892	Watkins, G. H.	Hollow Rock	Univ. Nashville	1878
1897	Watson, W. T., ex-Pres.	Lexington	Louisville Univ.	1870
1894	Webb, L. L.	Carroll	Louisville Univ.	1880
1903	White, E. H.	Rives	Col. P. & S., Balt.	1883
1904	Williamson, G. L.	Jackson	Vanderbilt	1904
1895	Witherington, J. B.	Munford	Vanderbilt	1878
1905	Witherington, A. S.	Munford	Mem. H. M. Col.	1904
1910	Witherington, R. L.	Munford	Mem. H. M. Col.	1909
1898	Witherspoon, J. A. Hon.	Nashville	Univ. Pennsylvania	1878
1907	Wright, J. L.	Ellbridge	Vanderbilt	1904
1895	Yarbrough, L. A.	Covington	Mem. H. M. Col.	1889

Please send correction in your name or address to Dr. I. A. McSwain, Secretary, Paris, Tenn.

## MISCELLANEOUS

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### **Experimental Poliomyelitis.**

In a ninth note on experimental poliomyelitis, S. Flexner and P. F. Clark, New York (Journal A. M. A., February 25), say that they do not find the disease to yield to any form of treatment, and at present we must view its self-limitation as being determined by the elaboration within the body, under the influence of the virus of the disease of substances of the nature of antibodies, the so-called immunity principles. What have come to be called abortive cases are coming to be of importance as regards the transmission of the disease. Our knowledge of this class of cases is still very imperfect and some doubts still exist as to their occurrence. They consider it desirable, therefore, to present the evidence bearing on this point. It is possible by neutralization tests to determine whether or not an attack of poliomyelitis has occurred in a given individual, whether paralysis has appeared or not. The test is made by mixing the blood-serum with the filtered virus, including the mixture at 37 C. for a few hours, and injecting it into a monkey. Normal human serum has no power to neutralize the virus, while serum from recovered cases of poliomyelitis has. This method does not afford a means of diagnosis, but it is of value as showing whether or not an abortive case of the epidemic has occurred. Up to the present, the immunity principles have been found in the blood of men and monkeys who have had the disease and to persist there for several years. They do not find it, however, generally in the cerebrospinal fluid or nervous tissues excepting in the early stages of the disorder. Cushing and Crowe have shown that hexamethyleneamin is in part eliminated into the subdural space, and it has therefore been employed to produce disinfection of the cerebrospinal fluid. It has been tried by Dr. R. S. Morris, of Baltimore and others in human cases of poliomyelitis, but it is clearly not a specific. The drug is well borne by monkeys and the authors have found that the incubation of the disease is prolonged and the paralysis is prevented in a certain proportion of cases. When the drug is administered by the mouth

and immune monkey serum by injection into the subdural space the paralysis can also be prevented and possibly with greater certainty. It has not been yet determined whether in monkeys thus cured there is a greater resistance to reinoculation than in untreated animals to a primary inoculation. Had the multiplication of the virus been entirely suppressed we should not expect to find any increased resistance. In immune serum protection the susceptibility to reinfection is about equal to that shown by untreated animals. It is important to know that the drug control of the virus of poliomyelitis within the body is a possibility, and also to learn that the successful results have been secured by inhibiting infection and not in restraining an already established infection by the virus. The importance of early diagnosis is noted by the authors, and they call attention to the fact that they have ascertained that, instead of being clear, the cerebrospinal fluid shows a very slight turbidity or opalescence at the height of the disease and an excess of protein matter. They have been able in a human case to make an early and certain diagnosis of the disease by the examination of the cerebrospinal fluid. They have before suggested that the nasopharynx acts in human beings as the portal of entry of the virus, as well as the source of its dissemination to other individuals. Concerning the habitat of the virus in nature outside of infected persons, we have no definite knowledge. The determination by Osgood and Lucas (Journal A. M. A., Feb. 18, 1911, p. 495) that the virus can survive in the nasopharynx of the monkey for nearly six months is highly significant. At this late period it does not persist in the nervous system. These observations indicate that monkeys, successfully inoculated, become in some cases after recovery passive carriers of the virus. Whether this will be proved true also of human beings remains to be seen, and it is imperative to make examinations as regards this point.

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**Barlow's Disease.**

A. B. Marfan (Ann. de méd. et chir. inf., Nov. 1, 1910) tells us that Barlow's disease shows itself in general about the age of ten months; it is characterized by anemia, pains in the bones, subperiosteal hemorrhages, especially in the lower limbs, and

ecchymoses of the gums when the child has teeth. It often is co-existent with rickets. It is rapidly cured by a change to antiscorbutic diet. There are changes in the bones of the limbs and skull. Of the latter the most serious are the changes in the orbit, causing exophthalmus and thickening of the upper lid with ecchymosis. The sternum and cartilages of the ribs are depressed, due to fractures of the anterior extremities of the ribs. The alterations are generally symmetrical, but may differ in degree on the two sides; the symmetrical lesions do not appear on the two sides at the same time, but succeed one another at a short interval; the intensity of the anemia is in relation with the number and size of the hematomas. There are a hematuiric form, a latent form, and anomalies of position of the hematomata. The duration is from three to six months. In some cases the hematomata suppurate from secondary infection. The osseous lesions consist of subperiosteal hemorrhages, fibrous transformation of the red marrow, and resorption of the chondrocalcareous layer. The special location of the hematomata is the lower part of the femoral diaphysis. The periosteum is separated all around the bone and appears like a very vascular membrane. Between the periosteum and the bone is a large blood clot. The periosteum is encrusted with bony deposits, an indication of the preservation of the osteogenetic function. These deposits account for the extreme hardness of the hematoma. Osseous rarefaction is a constant lesion; it occurs even in bones that are not involved in hematomata, and results in multiple fractures of the bones. The microscope shows that the cause of this condition is the disappearance of the osteoblasts in the forming bone trabeculae under the periosteum. The most generally accepted theory of Barlow's disease is that it is a form of infantile scurvy. It resembles adult scurvy in that both are caused by the absence from the diet of necessary natural products. It generally occurs in bottle-fed babies who have been fed on farinaceous foods, sterilized milk, or boiled milk. It appears only when these materials have been given for a long period of time.—American Journal of Obstetrics.

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#### **Transfusion in Pellagra.**

An account of twenty cases of pellagra treated by transfusion of blood by Drs. G. J. Winthrop and H. P. Cole, Mobile, Ala., is

published by Dr. Cole (Journal A. M. A., February 25). The patients were all in advanced stages or had been resistant to other recognized methods of treatment which had been fully tried in all. Of the twenty, seventeen recovered, and the author credits the transfusion with these. The larger proportion of the recovered patients were females (68.8 per cent). One relapsing patient was in an institution, constantly exposed to other cases, and may, the author thinks, be considered as a reinfection. His conclusions are given as follows: "In transfusion in twenty cases of pellagra we have found no ill effect resulting to the patients directly from the operation. We may safely resort to transfusion in the severe type of case, steadily retrogressing under approved therapeutic procedures. We have noted advantage in the employment of a donor who has never had pellagra. There is apparently no advantage in the use of a relative for a donor as compared to the use of a non-relative. The recoveries following transfusion in the grave type of cases (60 per cent.) compares most favorably with the recoveries (10 to 20 per cent.) in the same type of cases in which other therapeutic measures are employed. The employment of transfusion in the terminal stages of pellagra must be undertaken with a full knowledge of the difficulties and dangers of the operation. Without careful selection of the cases and unprejudiced conclusions this procedure will fall into an undeserved ill repute."

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#### Vaccination in the Philippine Islands.

Robert Olesen, Manila, P. I., thinks that the results of vaccination in the Philippines will form a good answer to the arguments of the anti-vaccinationists that vaccination is of no value. The systematic vaccination carried out under the authority of the health officers in the various towns has resulted in a great diminution in smallpox cases and deaths. In the unvaccinated state the natives have acquired a certain amount of immunity, and most of the cases are in children. None of the health officers has any knowledge of any disease or death that has been in any way due to vaccination. By the attempts of the natives to remove the virus several severe infections have been produced. No person who has once been successfully vaccinated

has died in the pest hospitals. When vaccinated persons have contracted smallpox it has been in a very much modified form. The people were at first much opposed to vaccination. But in one district where vaccination had been refused it was seen that only the unvaccinated had smallpox, and after an epidemic all the people came and begged to be vaccinated. A set of circulars sent out to all physicians brought out these facts. Recent successful vaccination is an absolute protection against smallpox. Protection lasts from six to twelve months and often much longer. Revaccination is advisable once a year. A fertile field for the disease is found among the unprotected infants, the people not being convinced that infants need vaccination. Over 90 per cent. of cases are in unvaccinated children. The difficulty of keeping the vaccine is great on account of the absence of ice in the tropical climate. No death from smallpox has occurred in Manila since June 15, 1909. Statistics show a marked decrease everywhere where vaccination has been done and an almost perfect eradication of the disease.—Medical Record, March 4, 1911.

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#### Potassium Permanganate Applications in Smallpox.

(W. Dreyer abs. Semaine Medicale, August 10, 1910).—The inconvenience of arranging a "bedroom" for the treatment of smallpox led the author to try the interception of actinic rays by painting the skin with a solution of potassium permanganate, a substance which, by reason of its antiseptic properties, exerts at the same time a favorable action on the suppurative process. A saturated solution of the salt is used, being painted on all parts affected with pustules. The application is renewed three or four times on the first, and if necessary also on the second day, so as to impart an intense brown coloration; subsequently a daily application is sufficient. The treatment not only reduces the suppuration, but diminishes the decomposition of the pus, and in the early cases reduces the suppuration to a minimum, thus curtailing the fever and diminishing the subsequent pitting. Where cardiac weakness exists this treatment should be employed with caution, the use of sodium permanganate being suggested to avoid the danger of potassium absorption.—The London Practitioner.

**Treatment of Whooping Cough.**

Berliner, writing in the *Munch. Med. Woch.*, has introduced another method for the treatment of whooping cough. He thinks that practically all of the long list of drugs usually employed are unsatisfactory, with the exception of quinine, used by him in a special manner. Finding that insufflation of quinine frequently produced paroxysms of coughing, he has for the past two years employed in all cases an ointment containing from 15 to 40 grains of quinine in from  $2\frac{1}{2}$  to 4 drams of lard, according to the age of the child. Three or four times a day a pellet of the ointment, about the size of a pea, is introduced into each nostril by means of a small glass rod. The child is placed on its back so that the ointment may penetrate to the deeper parts of the nasal cavity. In one case the improvement was immediate, but, as a rule, considerable benefit was secured at the end of three or four days. Not only do the paroxysms diminish in number, but they decrease in severity, the fit of coughing subsiding into an ordinary cough as it gets less frequent. Some relapses occur, but they yield to renewed treatment. The treatment is much more effective in the younger child. The general convulsions consequent on the paroxysms in children under two years of age cease, as a rule, as soon as this treatment is begun. The method has the additional advantage that it is easy of application.—*The London Practitioner.*

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**No "Colds" at the Poles.**

Lieut. Shackleton relates how, while in the Antarctic regions, the daily journeys were of course taken under atmospheric conditions involving the extremest cold; and the danger of "catching cold" is increased by the profuse perspiration induced in dragging sledges over miles of snow and broken ice lands. Nevertheless, neither the lieutenant nor a single one of his associates, during the whole of their Antarctic experience, suffered from bodily infirmity such as might ordinarily follow on exposure to extreme cold. Yet at the first port their vessel touched on the homeward voyage nearly every man, including the commander, had catarrh—no doubt germinal in etiology.—*Medical Times.*

# **Memphis Medical Monthly**

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## **TENNESSEE'S MEDICAL PRACTICE ACT.**

There is now pending before the Legislature of the State of Tennessee a bill to regulate the practice of medicine in this State. With some additions, the bill is practically a codification of the present laws.

It provides that the State Board of Medical Examiners shall consist of six graduated physicians of not less than six years' experience in the practice of medicine and surgery; four of these physicians to be representatives from the regular schools of medicine, one from the eclectic, and one from the homeopathic. These men are to be appointed by the Governor for a term of six years, and such appointments shall be made from a list of not less than twelve eligible physicians which are to be named by the State Medical Association representing the three schools of practice.

Applicants for license to practice medicine must have a diploma from a reputable medical college now requiring four courses of lectures of not less than seven months each. The board is also given the power to revoke licenses upon the ground of fraud in its proculal, or if the licensee has been guilty of unprofessional or dishonorable conduct. "Unprofessional or dishonorable conduct" is declared to mean:

1. The procuring or aiding or abetting in procuring a criminal abortion.
2. The obtaining of any fee on the assurance that a manifestly incurable disease can be permanently cured.
3. All advertising of medical business in which untruthful and improbable statements are made.

4. All advertising of medicine or means whereby the monthly periods of women can be regulated or menses re-established if suppressed.

5. Conviction of any offense involving moral turpitude.

6. Habitual intemperance or excessive use of narcotics..

The bill also aims to prevent any person from acting under the name or as the agent of any other person in the capacity of practitioner of medicine or surgery.

The Senate has practically eliminated the following section of the bill, a strong fight being made against it by the patent medicine people. The House has not considered the bill as yet, and it is urged that every member of the State Medical Association write to his legislators urging the necessity and importance of this protection:

"Sec. 17. Be it further enacted, That it shall be unlawful for any itinerant physician or itinerant vendor of any drug, nostrum, ointment or application of any kind, intended for the treatment of diseases or injury, to sell or apply the same; or for such itinerant physician or vendor, by writing, printing or other methods, to profess to cure or treat diseases or deformity by any drug, nostrum, manipulation or other expedient in this State, and whoever shall violate the provisions of this section of this Act shall be guilty of a misdemeanor; and, upon conviction thereof before a court of competent jurisdiction, shall be fined in any sum not less than \$100 and not exceeding \$400."

The State Board of Examiners is also authorized to accept licenses issued by other States having requirements which, in the opinion of the board, are equal to those of Tennessee, and which accept upon similar conditions the licenses issued by the State Board of Tennessee.

This is a good medical practice act and it should be passed without any modifications in favor of the patent medicine man or the faker, and it is the duty of every physician of Tennessee who has the welfare of the State and its people at heart to see or write to the members of the Legislature urging its passage.

## EDITOR'S NEWS NOTES.

**AMERICAN MEDICAL EDITORS' ASSOCIATION.** The forty-second annual meeting of the American Medical Editors' Association will be held at the Alexandria Hotel, Los Angeles, Cal., June 26 and 27, under the presidency of Dr. J. MacDonald, Jr. Unusual efforts are being made for this annual convention, and members are urgently solicited to be present. Plans already matured enable the executive committee to assure those who will attend a most interesting session, both from a literary as well as a social viewpoint.

**AMERICAN MEDICO-POLITICAL LEAGUE.** Under this imposing title a number of Chicago physicians have recently incorporated in Illinois, among them being: J. E. Waggoner, F. Tice, Lewis H. Bremerman, O. Tydings, Ralph H. Wheeler and G. Frank Lydston. The purpose of the league as set forth in the charter is in part as follows: "To procure the establishment of a national bureau of health, divorced from politics; the establishment of a uniform standard of medical requirements in the several States of the Union; encouragement and co-operation with all movements and legislation for food reform which shall be fair and impartial and founded on scientific premises; encouragement of political preferment of physicians as tending to secure just representation for the profession; encouragement of measures for the correction of hospital and dispensary abuses of charity."

**MURDER UP TO DATE.** St. Petersburg, Russia, is watching with interest the trial of one of its citizens accused of having committed murder by the administration of diphtheria toxin to his victim. The accused, a physician, is said to have made a secret confession to the police, which he has first modified and then retracted, to the effect that he was employed by a relative of the dead man to remove him without exciting suspicion, and that cholera germs were the means first chosen. These proving unsuccessful he easily obtained the diphtheria toxin.—*Medical Record*.

**LEPROSY CONTROL.** Secretary Ballinger, of the Department of the Interior, has asked Congress for an appropriation of \$30,000 in order that he may deal adequately with the numerous cases of leprosy that have appeared recently in Alaska. As Alaska has no quarantine laws, nor any means of affording pro-

tection from communicable disease of any kind, and as there is continual danger from Eskimos, Aleuts and Indians, who are ignorant of the first principles of hygiene, Gov. Clark, of Alaska, urges that the Marine Hospital Service be authorized to take jurisdiction of the cases.

**SLEEPING SICKNESS.** The Army Medical Museum at Washington has received a collection of flies and mosquitoes and many photographs intended to illustrate the origin and spread of the "sleeping sickness" in Africa. The work has been done by Maj. W. M. Roberts, of the United States Army, who during four months' leave of absence has been traveling in Northern Africa making an investigation of the disease.

**PLAUE IN CHINA.** The Chinese government, realizing the gravity of the situation, has begun active measures for the suppression of the plague, and has written to its foreign ministers instructing them to invite the governments to which they are accredited to send experts to the affected districts to study the disease. The worst center of infection appears to be Fudziadian, a suburb of Harbin in Manchuria, where as many as 1,500 deaths were reported in one week, and this town is now to be isolated as far as possible. On January 26, 160 deaths occurred at Harbin and 60 at Mukden. Cases also continue to appear in Pekin and many of the foreign legations have been closed.

**RAVAGES OF THE PLAGUE.** The Viceroy of Manchuria estimates that the fatalities from the plague in Manchuria have been 65,000; but this is declared by many to be little more than half of the actual number of deaths. Practically none of those stricken recover; infection of the lungs being rapidly followed by death. In the province of Harbin 250 deaths are said to occur daily, and as the frozen ground makes burial impossible, conditions are very serious. The people, however, have finally begun to consent to cremation. At Vladivostok efforts to enforce sanitary regulations resulted in a fight between Russian soldiers and Chinese residents, in which six persons were killed. London has been startled by a report that German agents in Manchuria are shipping to Europe large quantities of hair taken from the bodies of victims of the disease. It is said that the bodies of the dead found in the streets are invariably without queues, and that these are cut off to supply the demand for false hair. Whether the germs of the disease can be transmitted in this way, how-

ever, is more than doubtful. The Department of State at Washington has been advised that the opening session of the medical congress for the investigation of the plague will be held in Mukden on April 3.

**ON TRIAL FOR SELLING DIPLOMAS.** Dr. J. W. Decker, dean of the Gate City Medical College, which now has its headquarters at Dallas, Tex., is reported to be on trial in the Federal Court of Dallas on the charge of using the mails to defraud. Mr. J. N. Wilkerson, the attorney for the Texas State Board of Medical Examiners, is said to have succeeded in securing a medical diploma within thirty minutes after he made application for it.

**ANTI-MENINGITIS SERUM.** The Rockefeller Institute for Medical Research of New York announces that it has decided to discontinue the general distribution of anti-meningitis serum which it has carried on without charge since the discovery of this remedy. The work of preparing and distributing the serum will be turned over to public health authorities and commercial establishments, the New York City Department of Health being the first to undertake the regular production of the serum. The distribution of the serum will at first be free to all hospitals and physicians desiring it; but later such gratuitous distribution will be limited to hospitals and needy cases. Until centers of production can be evolved in other localities the New York Health Department will supply the serum on urgent requests from outside the State. Statistics show that the death rate from cerebrospinal meningitis has been reduced to less than one-third by the early use of the serum. Its efficacy being thus established the Rockefeller Institute will devote to other lines of research the money which has been expended in the production of the serum.

**MEMPHIS.** The establishment here of a great cotton oil mill by Proctor & Gamble and the investment of the Swift people in another factory adds still more to the lead that Memphis already has as the leading cottonseed produce market of the world.

**MEMPHIS.** Every railroad entering Memphis is spending hundreds of thousands of dollars this year in enlarging its terminal and mechanical facilities. There could be no surer index of the wide industrial and commercial growth of this city.

**THE NOBEL PRIZES.** As our readers know, the Nobel prize fund awards five prizes each year averaging from \$38,000 to \$40,000

each. Since 1900 nearly two millions have been thus distributed to leaders in physics, literature, promotion of peace, medicine and chemistry. The list of the scientific recipients forms an international Hall of Fame, the chemists thus honored being van't Hoff, E. Fischer, Arrhenius, Ramsay, Baeyer, Moissan, E. Buchner, E. Rutherford, W. Ostwald, and the 1910 recipient, O. Wallach, professor of chemistry at the University of Göttingen. The recipients of the medicine prize have been von Behring, D. Ross, Fin-sen, Pawlow, Koch, Cajal and Golgi, Laveran, Ehrlich and Metchnikoff, Kocher and the latest recipient, A. Kossel, professor of physiology at the University of Heidelberg. The last physics prize was awarded to van der Waals, professor of physics at the University of Amsterdam, the last literature prize to P. J. L. Heyse of Germany, and the peace prize to the International Peace Bureau at Berne. The balance between the various countries has been maintained with remarkable impartiality, but the majority of the prizes have gone to Germany. Only two have crossed the Atlantic, the peace prize given to President Roosevelt and the physics prize in 1907 to Prof. Michelsen, of the University of Chicago. It is a question whether the design of the founder of the prize fund has been realized to date; the awards have gone to men who were already resting on their laurels and the prizes have not served to foster new research to any extent. The committee in charge of the awards pays no attention to personal applications for prizes; the applications to be considered must come from scientific societies, institutions or other organized authority. It is possible that the greater preponderance of prize-winners in certain nationalities is because their institutions and societies have taken greater pains to present the claims of candidates in their respective nations.—Jour. A. M. Å.

MADAME CURIE AND THE ACADEMY OF SCIENCES. The recent candidacy of Mme. Curie for the vacant seat of M. Gernez in the Académie des Sciences of France has aroused much interest outside of that country, and the news of her defeat will doubtless be a disappointment to many who seldom feel any concern about the distribution of foreign academic honors. Justly or unjustly, public opinion outside of France will incline to interpret the result of the election as a discrimination, on grounds of sex, against a scientific investigator of high standing. The academy, however, has avoided the responsibility of officially excluding women.

As explained by our Paris correspondent, the agitating question of feminine candidaey was laid before the Institute de France, of which the Académie des Sciences is a component part. The institute passed a resolution advising respect for "immutable tradition," but declining to interfere with the autonomy of the five affiliated academies. The Académie des Sciences presented Mme. Curie as a candidate, therby tacitly admitting the principle of the eligibility of women. On the first ballot Mme. Curie received but one vote less than her successful rival. To what degree her defeat is to be attributed to the undoubtedly strong feeling against the admission of women cannot be judged from this distance. Her successful competitor is, we are assured, a member who confers honor on the illustrious body to which he has been elected; and it would be doubtless unfair to ascribe his election chiefly to prejudice against a woman candidate. The narrowness of the margin by which Mme. Curie was defeated suggests that a similar contest might some time have a different ending. The election of so distinguished a woman as Mme. Curie to the Académie des Sciences, if that should ever occur, would certainly add to rather than detract from the honor conferred on other members, since it would indicate that no personal consideration outweighed scientific attainments in the selection of members.—*Jour. A. M. A.*

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## BOOK REVIEWS.

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### *Gray's Anatomy.*

The announcement of a new edition of *Gray's Anatomy* interests every one concerned with medicine, student and practitioner alike, for it deals with the only science entering into every medical question. Henry Gray was a two-fold genius, as he combined a thorough knowledge of human structure with equal insight as a teacher. Neither of these qualities singly could have produced a book in which matter and method were so perfectly welded into an ideal teaching instrument. Gray's inventive mind devised the scheme of engraving the names of the parts directly on them, so that the eye caught at a glance

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Sodium Cacodylate, administered hypodermatically, has given remarkably good results in **SYPHILIS** (see Dr. John B. Murphy's report in the *Journal of the American Medical Association*, September 24, 1910). It has been successfully employed in the treatment of both simple and pernicious anemia. It is highly recommended in the malarial cachexia, neurasthenia, and certain diseases of the skin, as psoriasis. Its uses, in short, are practically the same as those of arsenic.

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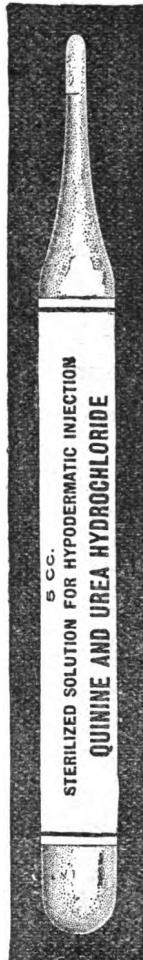
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**Anatomy, Descriptive and Applied.** By Henry Gray, F.R.S., late lecturer on Anatomy at St. George's Hospital, London. New (18th) edition, thoroughly revised, by Edward Anthony Spitzka, M.D., Professor of Anatomy in the Jefferson Medical College of Philadelphia. Imperial octavo, 1,496 pages, with 1,208 large and elaborate engravings. Price, with illustrations in colors, cloth, \$6.00 net; leather, \$7.00 net. Lea & Febiger, Publishers, Philadelphia and New York, 1910.

#### Duodenal Ulcers—Moynihan.

It is through the work of Moynihan that we are largely indebted for our present knowledge of the diagnosis and treatment of this lesion. This work forms the latest of the author's admirable contributions to abdominal surgery. The subject is treated in his usual clear and practical style, giving the reader an accurate picture of a condition which a few years ago was considered very rare, but which is now demonstrated to be very common. The diagnosis of this condition, Moynihan here tells

us, may be made "with a degree of accuracy not exceeded in the case of any other abdominal disease."

The most important chapter of the work is that on the diagnosis of the chronic duodenal ulcer. The clear and pithy description of symptoms is born of long and perfect familiarity with the disease, made complete by the living pathology of the operating table. He emphasizes the importance of the careful history in the accurate diagnosis. He states that he has "never operated on a case of protracted or recurrent 'hyperchlorhydria' without finding a duodenal ulcer." Also, that it is rare to find any excess of acidity in such cases where a test meal has been given. Careful study of this chapter, and that following on differential diagnosis, cannot fail to leave with the reader a well-defined picture of the disease.

In the discussion of the cure of chronic ulcer, the author finds it difficult to determine the place for medical treatment. As cases present themselves, the disease is so advanced that surgical treatment is practically always indicated. In the large majority of cases, gastroenterostomy, combined, or not, with excision or infolding of the ulcer, is most satisfactory. Excision alone may be practiced where no narrowing of the lumen may result from the suturing, but at present it is rare to get the ulcer before it has become too extensive. Resection of the duodenum is rarely required. In perforation of the ulcer, closure by suture was sufficient in about half the author's cases, and in the remainder gastroenterostomy was also performed.

After covering the various phases, from history to treatment, the author gives in detail a complete list of his cases to the beginning of the year 1909, so that one may study them and determine whether the premises justify the conclusions drawn in the text. The author has shown that many of the usual diagnoses, such as indigestion, gastralgia and such like, are due to ignorance of the pathology present, namely, duodenal ulceration, and that the symptoms are relieved by treatment of this lesion. Not only does the author claim in his book that duodenal ulcer is not a myth, but a demonstrable condition; in actual practice he lives up to the claim, showing to the satisfaction of visitors that ulcer actually is present.

The book is one of the most important contributions to modern surgery and is a distinct addition to the surgical literature of the nineteenth century.

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## Clinical Reports.

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This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

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 (Late Superintendent Central Kentucky Asylum.)

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For Nervous and Mental Diseases, Drug and Alcohol Addictions

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(Formerly Asst. Phys. to State Asylums at Austin and San Antonio, Texas.)

Your attention is called to a new and simple invention for administering ether for all operations upon the mouth and face, especially upon the nose and throat. Nose and throat specialists not already equipped with an apparatus of like nature should investigate this compact, inexpensive and simple device. It is manufactured by Messrs. Sharp & Smith, of Chicago, whose advertisement appears on another page of this issue.

### Functional Diseases of the Uterus and Appendages.

In the treatment of functional diseases of the uterus and appendages, Diovinburnia holds a most remarkable curative influence in its marvelous tonic effect on the entire uterine system, and is therefore indicated in all abnormal conditions, whether dysmenorrhea, amenorrhea, menorrhagia, or any functional wrongs of women. Aching back, bearing-down abdominal pains, soreness of the lumbar region, is an abnormal condition in which Diovinburnia is indicated, and should be administered in tablespoonful doses, three times a day in hot water.

## SANMETTO FOR GENITO-URINARY DISEASES.

A Scientific Blending of True Santal and Saw Palmetto with Soothing Demulcents  
in a Pleasant Aromatic Vehicle

A Vitalizing Tonic to the Reproductive System.

SPECIALLY VALUABLE IN  
PROSTATIC TROUBLES OF OLD MEN—IRRITABLE BLADDER—  
CYSTITIS—URETHRITIS—PRE-SENIILITY.

DOSE:—One Teaspoonful Four Times a Day.

OD CHEM. CO., NEW YORK.

*Clinical Reports***Sodium Cacodylate in Syphilis.**

Few articles appearing in the medical press in recent months have attracted more attention and comment than that by Dr. John B. Murphy, of Chicago, published in the Journal of the American Medical Association of September 24, 1910, in which the writer detailed the striking results obtained by him through the hypodermic administration of sodium cacodylate in the treatment of syphilis. Physicians who have not seen the article in question will be interested in the following abstract, as published in Therapeutic Notes:

"Administered in doses of one-half to two grains hypodermically, its action was prompt and efficacious. Chancres became clean ulcers without induration in forty-eight hours; mucous patches cleared up in twenty-four to forty-eight hours; ulcers of the palate and pharynx healed in three to six days. In a child nine months old one-fourth grain injected into the pectoral muscle caused a papillary syphilide to disappear in forty-eight hours. Two two-grain doses, twenty-four hours apart, completely relieved the pain of a patient who suffered from active gastric crises (luetic), which usually lasted three weeks. An advancing perforating ulcer of the palate, which had resisted injections of one-fourth grain of mercuric bichloride daily, promptly yielded to sodium cacodylate, two injections of three-fourths grain each. The ulcer was healed in six days.

"Dr. Murphy suggests that sodium cacodylate be employed in primary doses of two to four grains, depending on the size and strength of the patient, and not repeated within three or four days, unless there are special indications for it."

Sodium cacodylate, in sterile solution, is marketed by Parke, Davis & Co., in sealed glass ampoules containing three-fourths grain and three grains, respectively, of the arsenic salt. In this connection it is proper to emphasize the importance of specifying a preparation that is known to be pure. Parke, Davis & Co. lay especial stress upon the purity of their product.

"nothing is more estimable than a physician, who, having studied nature from his youth, knows the properties of the human body, the diseases which assail it, the remedies which will benefit it, exercises his art with caution and pays equal attention to the rich and poor."

Successful therapy is founded on these principles. The treatment of inflammatory conditions is only in so far successful as the proper remedy is chosen and applied.

The prompt relief which has resulted from the use of antiphlogistine in affections due to superficial or deep-seated inflammations, combined with the generous attitude of the medical profession toward this preparation, would clearly indicate that the physician exercises his art with the objective viewpoint to do the best for his patient.

Our aim to prepare antiphlogistine with scientific accuracy and to suggest its employment, wherever moist heat is indicated, is due to our desire to supply a remedy which will benefit both the patient and the doctor.

Our co-operation seems to have been appreciated, for which we give thanks.

*Clinical Reports*

**Grippal Cough, Laryngitis, Bronchitis.**

In these afflictions, Antikamnia is indicated for two reasons: First, because of its absolute power over pain, at once removing this element of distress and placing the whole system in the best possible condition for a speedy recovery. And second, because of its power to control inflammatory processes, lowering the fever by its peculiar action on the nervous system. Codeine is strongly indicated because of its power as a nervous quietant, often quickly and completely controlling the cough. In nervous coughs, irritation of the throat, laryngitis, bronchitis and phthisis, where the cough is altogether out of proportion to the amount of expectoration, Antikamnia and Codeine tablets will give prompt satisfaction. In fact, in cases of nervous coughs, irritable throat, so commonly attendant upon influenza and la grippe, as well as in sub-acute laryngitis, and slight bronchitis, this tablet alone will often so control the cough that the disease rapidly subsides. This is not strange when we remember that nothing could keep up this irritation more than constant coughing. In the more severe cases of bronchitis and in phthisis, the patient is not only made more comfortable, but the disease itself is brought more directly under control by checking the excessive coughing, relieving the pain and bringing the temperature down to the normal standard.

---

**The After-Treatment of Catarrhal Colds, Etc.**

The various colds, "gripes," and catarrhs, that afflict the respiratory mucous membranes during the winter months, are extremely likely to leave their traces upon the general systemic vitality, in the form of a greater or lesser degree of anemia. This is specially true of those whose resistance is "below par," i. e., elderly people, young ill-nourished children, and weaklings from whatever cause. The constitutional after-treatment of respiratory disorders, among this class of patients, is usually more honored in the breach than in the observance. There can be no better routine practice than to order Pepto-Mangan (Gude) as a general tonic and reconstituent, especially when anemia is apparent. This exceedingly pleasant and ferruginous reconstructive is so distinctly palatable as to render it generally acceptable to all patients, and is so entirely free from irritant properties as to insure its ready toleration without causing constipation or disturbances of digestion.

### Clinical Reports

#### To Guard Against the Inroads of Disease.

An excellent way to guard against the inroads of disease is to feed to the tissues nutritious elements which, when incorporated within them, add greatly to their powers of resistance. For generations cod liver oil and the hypophosphites have been considered as leading "tissue makers," and as combined in Cord. Ext. Ol. Morrhuæ Comp. (Hagee) they have grown into still greater favor. Cordial of the Extract of Cod Liver Oil Compound (Hagee) charges the tissues with the very elements needed to resist disease processes, and for this reason it has held the profession's favor these many years.

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In disordered conditions of the liver, indigestion, intestinal atony and neurasthenia, the effects of Prunoids is most beneficial. In diseases of women, particularly those occurring at puberty or the climacteric, and in connection with the menstrual function, Prunoids are markedly efficient as a safe and thorough laxative.

In prescribing the products of manufacturing pharmacists, we should be guided to a great extent by the business standing of the manufacturers. No other house in the South or West has a better reputation for strict integrity than the Robinson-Pettet Company, Louisville, Ky. We do not hesitate to recommend the preparations advertised by them in this issue.

## SAL HEPATICA

The Original Effervescent  
Saline Laxative and  
Uric Acid Solvent.

A combination of the Tonic, Alterative and Laxative Salts similar to the celebrated Bitter Waters of Europe, fortified by the addition of Lithia and Sodium Phosphate.

It stimulates the liver, tones intestinal glands, purifies alimentary tract, improves digestion, assimilation and metabolism. Especially valuable in

RHEUMATISM, GOUT, BILIOUS  
ATTACKS AND CONSTIPATION

Most efficient in eliminating toxic products from intestinal tract or blood, and correcting vicious or impaired functions.

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**Dimensions:** 8 inches long, 5 inches high, 3 $\frac{1}{2}$  inches wide. Case is covered with solid leather, hand stitched. Contains 5 one and one-half ounce glass-stopper bottles, 7 six-dram, 9 four-dram vials. It has one nickel clasp. Bottles arranged in three rows, with pocket for powder, etc. Rings for straps and well lined.

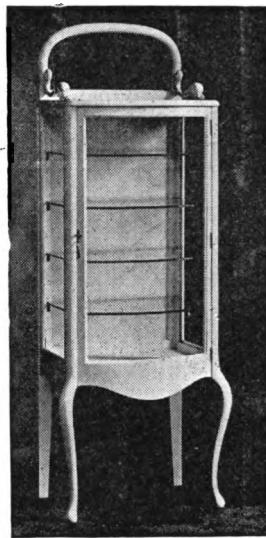
"Western" silver-plated springs for holding vials. Straps 25c extra.  
Price ..... \$5.00

## Cabinet

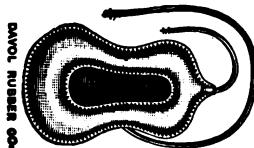
This Cabinet is made of Oak, finished in white Enamel, size 64 inches high, 24 inches wide and 17 inches deep. It has four polished plate glass shelves. Beveled French plate mirror at the top. It makes a very handsome and serviceable cabinet for the surgeon's office or small hospitals. We offer this cabinet at a special low price.

Memphis White Enamel Wood Instrument Cabinet.....\$32.50

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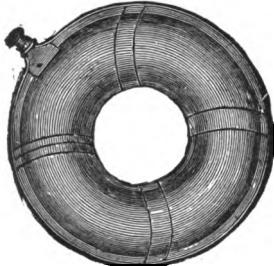


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The Kelly Perineal Pad—Made by Davidson Rubber Co., and are  
guaranteed to be the best made.  
Price, each.....\$3.50



The Kelly Obstetrical Pad—Made by the Davidson Rubber Co.  
The None better made, and has their well known velvet finish.  
Guaranteed for this climate.  
20x44 inches, each.....\$4.50  
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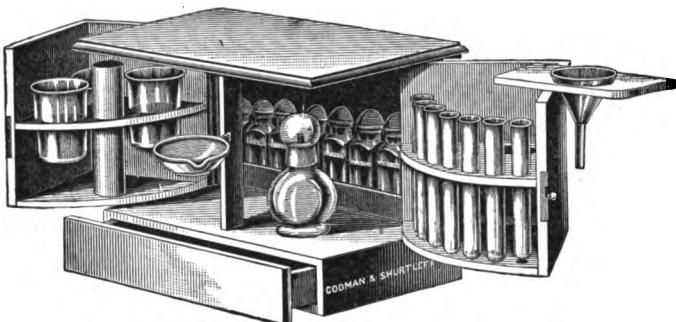
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Dutro & Hewitt Co.

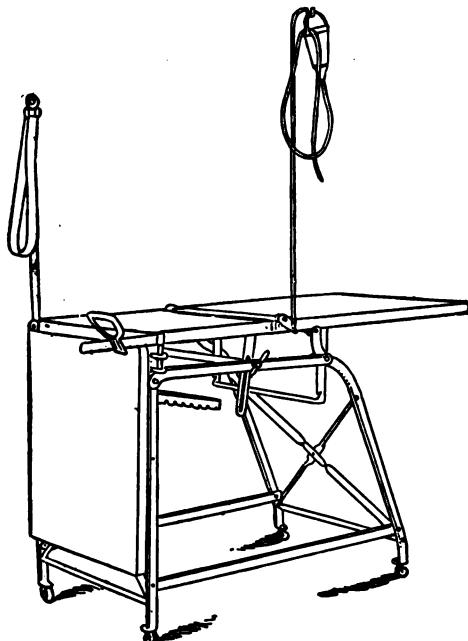
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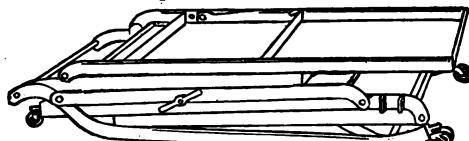
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Showing Crutch and Holder, Stirrup,  
Stirrup Holder and Irrigator.



The Junior folded for packing and transportation

With Crutches and Stirrup	• • •	\$16.00
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## THE OHIO BALL-BEARING CHAIR



PRICE

**\$40.00 Cash**

**\$45.00 on Time**

**Dutro & Hewitt Co.**

**Memphis, Tenn.**

### Clinical Reports

#### Laryngeal or Winter Coughs.

The Journal of Nervous and Mental Disease, in an article by Dr. Walter M. Fleming, says: In acute attacks of laryngeal or winter cough, tickling and irritability of larynx, Antikamnia and Codeine Tablets are exceedingly trustworthy. If the irritation or spasm prevails at night the patient should take one tablet an hour before retiring and repeat it hourly until the irritation is allayed. Allow the tablet to dissolve slowly in the mouth, swallowing the saliva. After taking the second or third tablet the cough is usually under control, at least for that paroxysm and for the night. Should the irritation prevail in the morning or at midday, the same course of administration should be observed until subdued. In neuralgia, in short, for the multitude of nervous ailments, he doubts if there is another remedial agent so reliable, serviceable and satisfactory, and this without establishing an exaction, requirement or habit in the system, as morphine does.—The New York Medical Journal.

---

#### The "City" Anemic.

The hard hum-drum city life, especially of those whose days are spent indoors, in offices, bending over desks, ledgers, and school books, is almost certain, sooner or later, to leave its traces upon the man, woman or child thus unfortunately situated. General sluggishness of metabolism, due to indoor confinement in a vitiated atmosphere, and lack of exercise, is followed by failing appetite and later by degenerative blood changes of anemic nature. While Pepto-Mangan (Gude) can not, of course, remedy the cause of the anemia and general devitalization, it almost always assists materially in overcoming the anemic blood state, increases appetite and acts as a real tonic and general reconstructive. As Pepto-Mangan (Gude) is free from irritant effect upon digestion, it is readily borne and quickly absorbed and assimilated, and as it is non-astringent it does not cause or increase constipation.

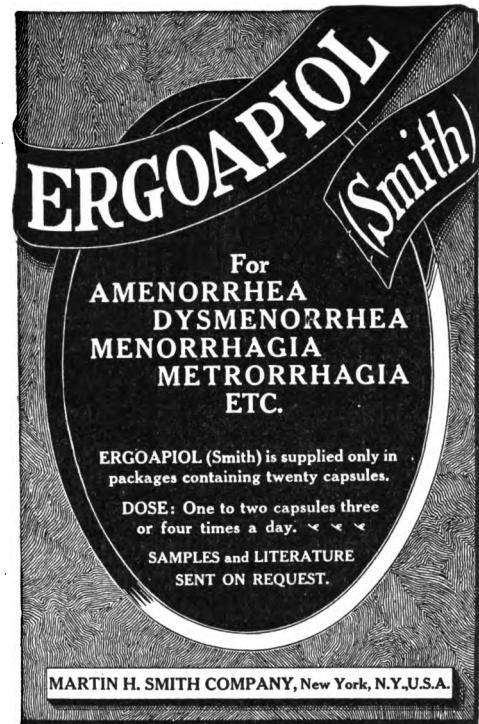
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Chemical Food is a mixture of Phosphoric Acid and Phosphates, the value of which physicians seem to have lost sight of to some extent, in the past few years. The Robinson-Pettet Co., to whose advertisement in this issue we refer our readers, have placed upon the market a much improved form of this compound, "Robinson's Phosphoric Elixir." Its superiority consists in its uniform composition and high degree of palatability.

### Congested Portal Circulation.

Chonia acts purely as an hepatic stimulant, and produces a therapeutic action on the liver that cannot be produced by any other remedy in the *Materia Medica*—never causing nausea or nervous prostration, which so often follows efforts to remove the congested condition of the portal circulation by the severe hepatic remedies.

"Nothing too strong can be said in favor of Tongaline. I have prescribed it many times, and it has proved satisfactory in every case."



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For the Care and Treatment of Nervous Diseases

New, Absolutely Fire-Proof Building

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## Malaria and Its Manifestations IS JUST WHAT YOU NEED

A concise presentation of history, etiology, symptomatology and diagnostic methods. With the most thorough and exhaustive methods of treatment of any work of its kind on the subject, containing the allopathic, alkaloidal, eclectic and physiotherapeutic treatments.

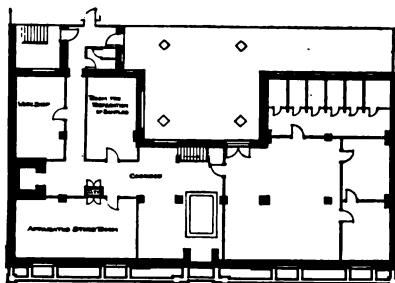
**PRICE, \$1.50. Personal check accepted**

**DR. J. H. McCURRY**

**GRUBBS, ARKANSAS**

*Clinical Reports***The New Lilly Science Building.**

For a number of years the scientific departments of Eli Lilly & Company have made such rapid growth that the need of larger quarters became imperative. Nearly two years ago preliminary plans were drawn for a special scientific building, and after many changes final plans were agreed upon late last summer. Work began upon the new building in September and has progressed with little interruption through the winter. The contractors expect to have the building ready for occupancy by June 1st. In architecture, arrangement and equipment the structure will be one of the best of its kind. The outside walls are of red, hydraulic pressed brick, with white terra cotta trimmings. The interior walls and floors are of reinforced concrete, rendering the building fireproof.



BASEMENT

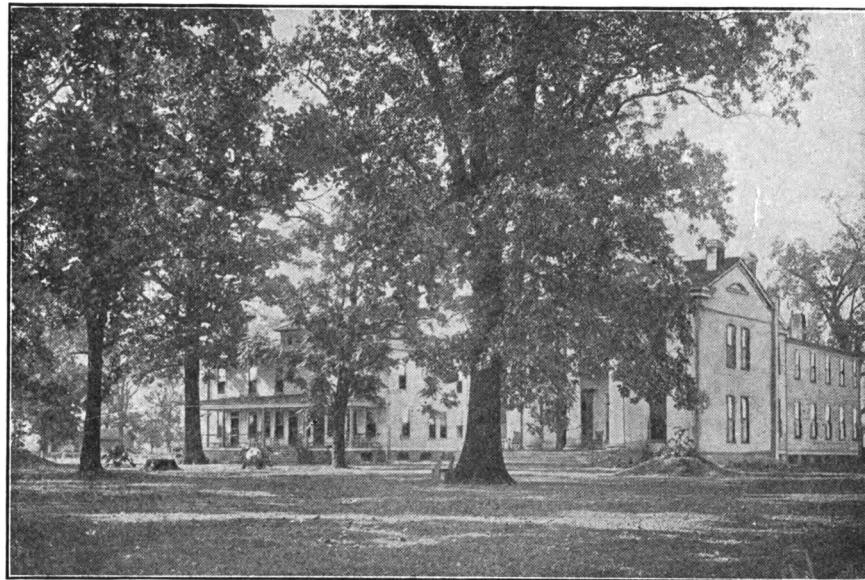
The basement will be used largely as a store room to supply the various departments with material for tests and experiments; a dumb waiter connects it with the other floors. In one corner is a shop equipped with machinery and tools for repairing and manufacturing delicate apparatus employed in the scientific laboratories. The basement also houses a still for the preparation of distilled water for chemical and research work, and a special milling equipment for grinding crude drug samples for chemical and physiological tests.

MEMPHIS

29

# Lynnurst

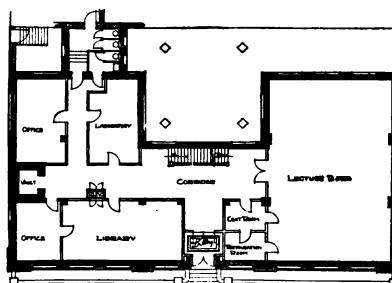
TENNESSEE



## A PRIVATE SANITARIUM FOR NERVOUS DISEASES MILD MENTAL DISORDERS AND DRUG ADDICTIONS

A Rest Home for Nervous Invalids and Convalescents requiring environments differing from home surroundings. Diseases of Metabolism, Anemia and the complications and sequelæ of Chronic Malaria also treated. Large Grounds. Two Buildings. New and Modern Equipment. Hydrotherapy, Electrotherapy, Massage and Rest Treatment. Experienced Nurses. Climate mild. Artesian, Chalybeate and Soft Waters.

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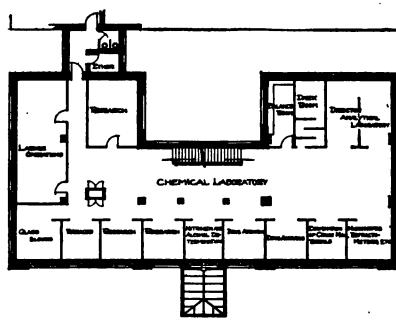


FIRST FLOOR

The first floor has a handsome street entrance protected by a large glass canopy extending over the sidewalk. Across the north end of this floor is a lecture room capable of seating 200 comfortably. It is here that Lilly salesmen and department heads will assemble to witness demonstrations and hear

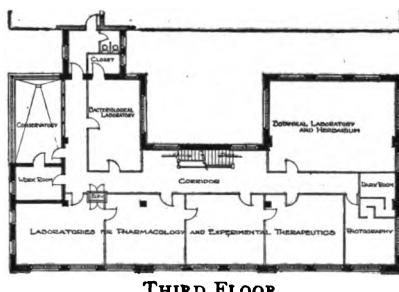
### *Clinical Reports*

lectures upon subjects related to manufacture and sales work. The rostrum is provided with an experiment table, which is supplied with compressed air, water, steam, gas and electricity. A ventilating hood with exhaust will remove all noxious fumes. This lecture room is available to local scientific societies and for entertaining visiting classes from medical, pharmaceutical and other technical schools. Adjoining the assembly room is a small preparation room and storage for apparatus. One of the most interesting equipments of the lecture room is a modern projection apparatus adapted to regular lantern slides, microscopic slides and opaque objects. Along the front of the building, south of the main entrance, as shown in the plan above, is a well-lighted, roomy library, which will contain many thousands of volumes of scientific and technical works, with ample desks and other accommodations for the staff. The library is in charge of a professional librarian, who is also a pharmacist. Adjoining the library is the office of the director of the scientific departments. Across the corridor from the library are the office and laboratory of the head of the pharmaceutical development work.



The second floor is occupied entirely by chemical laboratories for research and routine work. Some of the features of this floor are a dark room for spectroscope, polariscope and other instruments of this class; a balance room with balances mounted on heavy stone shelves projecting from the masonry of the wall. Along the front of the second floor are nine alcoves, each a complete chemical laboratory in itself and large enough to accommodate two chemists. In one corner of the floor is a fireproof room for ether and other inflammable liquids used in research work. There are also rooms specially designed for research, for large operations, and commodious quarters for the director of the analytical laboratory.

*Clinical Reports*



The third floor accommodates several departments; the botanical laboratory, with its large general herbarium of mounted plants and an immense collection of crude drugs in glass jars, is in the northwest section; connected with it by corridor and in the southwest corner of the floor is a conservatory of the latest type, with work room attached. This equipment enables the botanical department to conduct a number of experiments with plants throughout the year, supplementary to the drug culture experiments which the department is carrying on in a larger way in the field near Indianapolis and in other parts of the country, where climate is adapted to the species under investigation. On this floor there is also a bacteriological laboratory and a photographic operating room with a dark room. The remainder of the floor is occupied by the departments of pharmacology and experimental medicine.

In the attic there is installed a large exhaust fan for ventilating the building, drawing fumes and gases from the different laboratories. The remainder of the attic is devoted to supplies for pharmacological experiments.

By June 1st, or soon after, Eli Lilly & Company hope to be able to throw the new science building open to visitors, and will welcome pharmacists and physicians to inspect it, as it represents one of the best equipments of its class, and is a fine illustration of the intimate connection of science and modern pharmaceutical manufacturing.

---

The preparations of "Pepsin" made by Robinson-Pettet Co. are endorsed by many prominent physicians. We recommend a careful perusal of the advertisement of this well-known manufacturing house. (See page 6.)



Exterior of Tent Cottage.



Grounds of Ranch Sanitorium.



Interior of Tent Cottage.

# RANCH SANITORIUM FOR TUBERCULOSIS

**DR. J. W. LAWS, Physician in Charge**

**Temperature:**

Mean Maximum, 65 Degrees  
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Mean Annual, 52 Degrees

Situated ten miles east of Fort Stanton  
Location of U. S. Sanatorium for Tuberculosis  
Altitude, 5,500 feet. Annual Sunshine, 306 Days

**RATES:**  
**\$50 PER MONTH**

**Lincoln, New Mexico**

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### The New Local Anesthetic in Ampoule Form.

In consideration of the growing demand for quinine and urea hydrochloride for local anesthesia, Parke, Davis & Co. are now marketing this valuable combination in convenient ampoule form, and the physician can procure it in one per cent. solution, absolutely sterile and ready for use. The ampoules contain 5 cc. of the solution each, and are supplied to the trade in boxes of six.

Quinine and urea hydrochloride is being used in a great variety of operative procedures with pronounced success. As a local anesthetic it is held by many physicians to be superior to cocaine, a contention which would seem to have warrant in view of the fact that the preparation is not toxic even in large doses; that it tends to restrain or prevent hemorrhage, and that the anesthesia produced by it is persistent. The latter point is worthy of especial emphasis. The anesthetic effect lasts for hours, sometimes for days, an important factor in connection with rectal and other operations that may be classed as painful.

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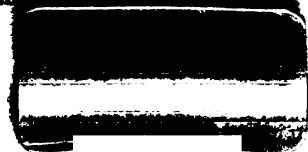
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### Useful Remedy for the Heart.

"The great bulk of clinical evidence leaves no doubt that Cactina Pillets is an eminently useful remedy for the heart when properly indicated and properly applied. At any rate, the wealth of facts gleaned from practical bedside experience cannot fail to stimulate the interest of every open-minded physician who is striving constantly to accomplish the best possible results in the best possible way.

"For years I have used Tongaline, and I consider it a valuable arrow in the quiver with which to fight that hydra-headed evil, rheumatism, especially when there are an...



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*"The physician has no higher nor nobler service to perform than to secure for his suffering patients prompt surcease of pain."*

In accomplishing effectual analgesia, however, the painstaking practitioner will at the same time always aim to cause the least possible embarrassment to physiologic processes. Of all anodynes, therefore,

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is the most acceptable, because it affords not only the most gratifying relief from pain but with none of the narcotic or toxic effects common to other opiates.

Papine presents the anodyne principle of opium with the narcotic, nauseating and constipating elements removed. In consequence it does not suppress the secretions, cause cerebral excitation, nor show habit-forming tendencies.

To the result-seeking, conscientious physician, Papine cannot fail to appeal as "the ideal analgesic."

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